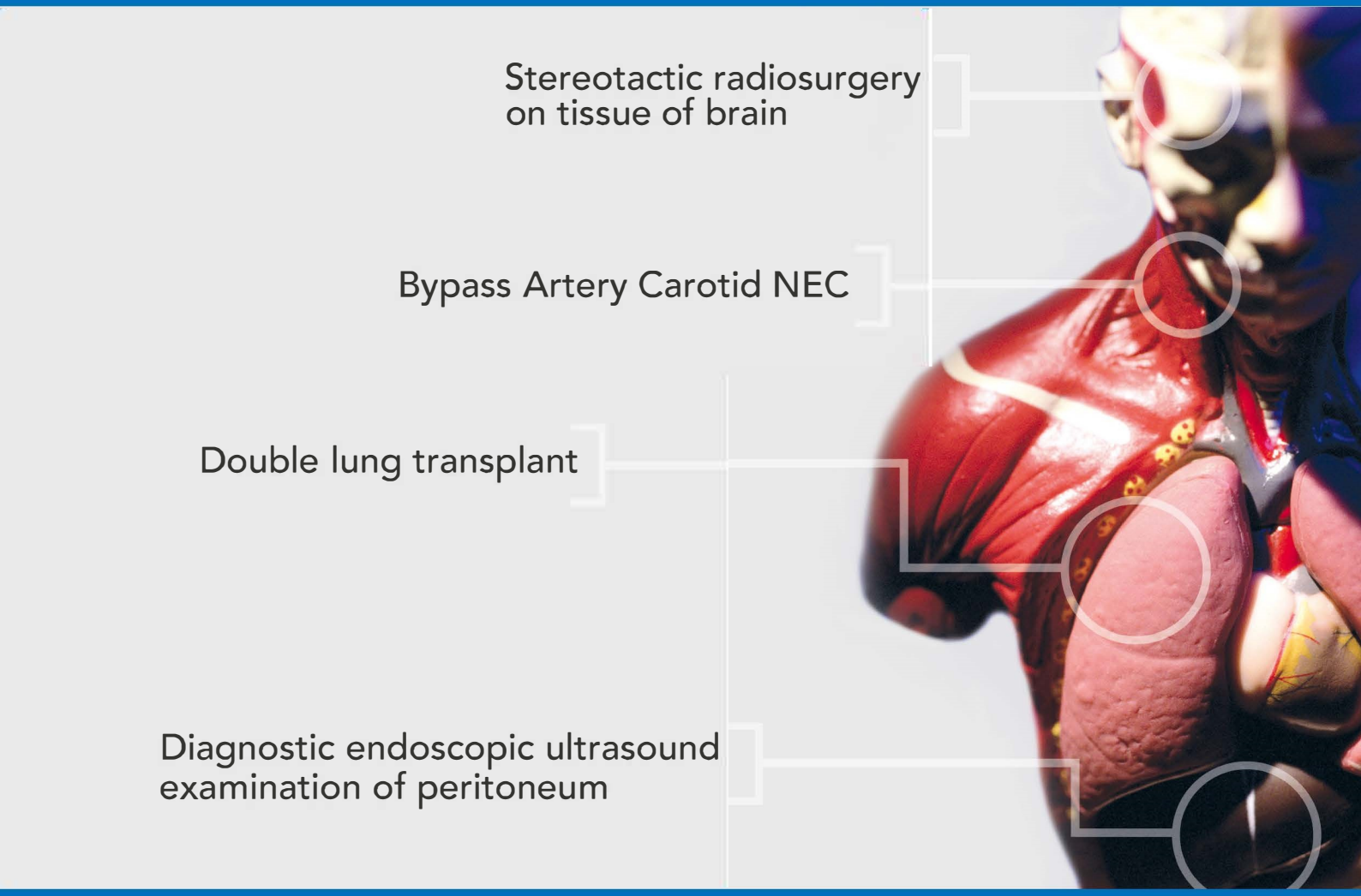
NHS England



National Clinical Coding Standards OPCS-4 (2024)

Accurate data for quality information

Terminology and Classifications Delivery Service

National Clinical Coding Standards OPCS-4

Accurate data for quality information

Produced by:

Terminology and Classifications Delivery Service
NHS England
7 and 8 Wellington Place
Whitehall Road
Leeds
LS1 4AP
Information.standards@nhs.net
http://systems.digital.nhs.uk/data/clinicalcoding

Authorised amendments to this publication are compiled and issued by the Terminology and Classifications Delivery Service.

Date of issue: January 2025
Version: 11.2

OPCS-4 CONTENTS

INTRODUCTION

The UK OPCS Classification of Interventions and Procedures (OPCS-4) was developed for use in the collection of intervention and surgical procedure information. The purpose of OPCS-4 is to permit the systematic recording, analysis, interpretation and comparison of surgical procedure and intervention data collected in the NHS. OPCS-4 is used to translate surgical procedures and interventions from words into alphanumeric codes, which permits easy storage, retrieval and analysis of data. The classification comprises two volumes:

- Volume 1: Tabular List: includes classification codes and titles at three- and four-character levels, historical background and information about OPCS-4
- Volume 2: Alphabetical Index: includes index terms for interventions and surgical procedures, surgical eponyms, abbreviations and surgical suffixes.

The *National Clinical Coding Standards for OPCS-4* are to be used with the two volumes of OPCS-4. They reinforce the classification rules and coding conventions inherent in the OPCS-4 Volumes 1 and 2, give specific instructions for procedure coding including for those areas of potential ambiguity (as far as practically possible) or where data analysis or user feedback requires additional information to safeguard data consistency and comparability. They also include instruction that cannot be embedded into the classification.

Compliance with OPCS-4 and these coding standards enables consistent, accurate and uniform coding which in turn supports the collection and comparison of local and national data across time.

The content type and level of detail within this publication is primarily aimed at a clinical coding professional and therefore presumes the user:

- Understands the use of the OPCS-4 classification
- Is trained in the abstraction of relevant information from the medical record
- Possesses knowledge of anatomy and physiology
- And for coding purposes, are aware of the methods and processes used when a procedure/intervention is performed on a patient.

The *National Clinical Coding Standards OPCS-4* are the definitive source of clinical coding standards for use in the NHS in England.

These clinical coding standards are also used in Northern Ireland and Wales, with some local variance. For information on specific use of the OPCS-4 classification, clinical coding standards, data definitions and collections in Northern Ireland, Wales and Scotland contact the respective national centre:

- Northern Ireland – Digital Health & Care Northern Ireland – About DHCNI Data
- Wales – Digital Health and Care Wales Information Design and Standards Development

- Scotland – Terminology Services and clinical coding - Services - Public Health Scotland

The NHS Classifications Browser provides a way to browse and search the OPCS-4 classification online. It is regularly updated to reflect changes to the OPCS-4 classification and National Clinical Coding Standards to support consistent application of the classification codes by clinical coders. It is freely available online to anyone with an internet connection.

Background

The OPCS-4 is a statistical classification of interventions and surgical procedures undertaken in the National Health Service (NHS) reflecting current clinical practice. OPCS-4 supports various forms of secondary uses of information essential for planning and improving patient care. Among these secondary uses are:

- Operational and strategic planning,
- Resource use,
- National and local planning and performance management,
- Research and epidemiology,
- Department of Health initiatives, and
- NHS payment system.

In England the classification of surgical procedures and interventions using OPCS-4 is a mandatory national requirement for the NHS Admitted Patient Care (APC) Commissioning Data Set (which includes day cases) and other data sets. The requirements for data sets and related definitions are specified in the NHS Data Model and Dictionary.

In England OPCS-4 is an approved Information Standard published under Section 250 of the Health and Social Care Act 2012, see DAPB0084: OPCS Classification of Interventions and Procedures.

Where errors have been identified in the printed OPCS-4 books following publication these will be notified in the ***ICD-10 and OPCS-4 Classifications Content Changes*** document.

History of the development of OPCS-4

A statistical classification of surgical operations has been available for use in the United Kingdom (UK) since 1944 when the Medical Research Council published one which identified 442 categories of operation. The then General Register Office prepared and issued an updated version in 1950, and revisions to this were subsequently issued in 1956, (first revision), 1969 (second revision) and 1975 (third revision).

This first classification contained 664 un-subdivided three-character categories. It was revised in 1956 with the addition of 10 categories, and again in 1969 at which time the three-character categories were increased to 731. Some of these categories were subdivided

(extended to four-character subcategories) so that the classification contained 1183 valid codes. The third revision, in 1975, further expanded the classification to 1426 valid codes.

The fourth revision of the OPCS-4 was conceived in 1983 as a result of one of the recommendations in the first report in 1982 of the Steering Group on Health Services Information (SGHSI), chaired by Mrs E Korner.

The SGHSI recommended that, “as a matter of urgency, OPCS should provide operation codes, which reflect current clinical practice and develop procedures for the frequent updating of the classification”.

The fourth revision of OPCS was initially issued in 1987 with definitive publication and implementation in 1990. The general objectives of the revision process, which began in 1983, were:

1. To identify and classify current surgical operations with particular reference to the incorporation of recent innovative techniques.
2. To eliminate rarely performed operations but to include procedures not requiring the full operating theatre environment.
3. To provide a flexible classification, responsive to less defined specialty boundaries and capable of future expansion.

Both the Tabular List and Alphabetical Index were updated in January 1990 and the Alphabetical Index was again revised in April 1993. OPCS-4 then contained 1183 three-character categories all of which were subdivided resulting in over 4000 valid codes.

It was originally devised as an instrument to provide the best possible basis for accommodating current systems and future developments for data on surgical operations. As well as maintaining the planned objective, the fourth revision also incorporated two further general aspects. It provided a definition of an operative procedure and outlined the concept of MAIN operation during an episode of care.

From 1995 a review of OPCS-4 was completed consulting with users to identify future need and inform future strategic direction.

In 2002 a project to develop an up to date intervention classification was commissioned by the Information Policy Unit (IPU). A proposal on behalf of the former NHS Information Authority and the IPU to produce a requirement for the development of a new classification was considered by the Information Standards Board on 19 April 2002 who then submitted their recommendations to Sir John Pattison and the National Information Policy Board (NIPB) for their approval. On 4 July 2002 the NIPB approved the proposal for this work to go ahead.

The former NHS Information Authority initiated the project to deliver a new intervention classification to replace OPCS-4.2 to support the DH Financial Flows project known as

Payment by Results. A review of this project was undertaken in March 2005 with the migration of the project to NHS Connecting for Health on 1 April 2005. The decision was taken at this stage to develop and enhance OPCS-4.2 to meet the needs of the Payment by Results programme which relies on detailed and accurate coding.

Consequently, OPCS-4.2 was enhanced during 2005-6 to support delivery of an updated classification for implementation across the NHS from April 2006. The project was completed in close collaboration with the Department of Health and with the NHS Information Centre for health and social care (IC) revising Healthcare Resource Groups (HRGs). In addition, input was received from clinical members of the clinical Expert Working Groups co-ordinated by the IC, which represented the Royal Colleges and professional associations. The result was OPCS-4.3, reflecting changes in clinical care in recent years enabling clinicians, in cooperation with clinical coders, to better describe patient care information. As a result this improved the quality of clinical procedural data collected by the NHS.

At the end of the project the responsibility for the development and maintenance of the OPCS-4 classifications was transferred to the NHS Connecting for Health national Clinical Classifications Service, now known as the Terminology and Classification Delivery Service.

Since September 2007, the Terminology and Classifications Delivery Service has made it easier for stakeholders to provide requests for change and track their progress with the launch of the online OPCS-4 Requests Portal. This was designed so anyone could submit their suggestions whenever it suited them.

The OPCS-4.5 release of the classification was the first which included requests for change received through the portal from stakeholders of the NHS. The OPCS-4 Requests Portal continues to provide the mechanism for all stakeholders to submit their requests for change. https://isd.digital.nhs.uk/rsp/

The development and maintenance of the classification is undertaken by the Terminology and Classifications Delivery Service at NHS England and will continue until further notice.

Clinical coding

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

Clinical coder

A clinical coder is the health informatics professional that undertakes the translation of the medical terminology in a patient's medical record into classification codes. A clinical coder will be accredited (or working towards accreditation) in this specialist field to meet a minimum standard. Clinical coders use their skills, knowledge and experience to assign

codes accurately and consistently in accordance with the classification and National Clinical Coding Standards. They provide classification expertise to inform coder/doctor dialogue. Clinical coders must abide by local and national confidentiality policies and codes of practice as a breach may lead to disciplinary action, a fine or, in the case of a breach of the Gender Recognition Act 2004, possible prosecution.

Care professional admitted care episode and Hospital provider spell

A clinical coder must assign OPCS-4 codes to the procedures recorded in the medical record for each care professional admitted care episode (hereafter referred to as ‘episode’) within the hospital provider spell for the Admitted Patient Care (APC) Commissioning Data Set (CDS) (which includes day cases).

A hospital provider spell may contain a number of episodes and the definitions for these terms are found in the NHS Data Model and Dictionary at: http://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.

An episode can be a consultant episode (hospital provider), a midwife episode or a nursing episode. This term replaces the previous term ‘finished consultant episode’ commonly abbreviated to “FCE” which was 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://www.datadictionary.nhs.uk/

Emergency Care Department attendance – Decision to Admit

The Emergency Care Commissioning Data Set (ECDS) is one of the mandated data flows for Health Care Providers across the NHS, England. In CDS V6-2-3 Type 011 – Emergency Care CDS emergency care attendances were mandated to flow nationally from 01-08-17. See DCB0092-2062 for more information.

All activity occurring under the responsibility of the Emergency Care Department is part of the Emergency Care Department Attendance and coded as such, including when the patient temporarily leaves the Emergency Care Department, e.g. for an X-ray.

When the patient’s care contact originates as an Emergency Care Department Attendance, but later a clinical decision is made to admit the patient to a Health Care Provider, this is described as a ‘decision to admit’. The 'Decided to admit date’ and ‘Decided to admit time’ is recorded at the time when the clinical decision to admit is made.

The ‘Decided to admit date’ and ‘Decided to admit time’ or ‘Admission date’ trigger the start time for an episode within the Admitted Patient Care CDS.

Following the decision to admit any recorded activity from that point on becomes part of the Admitted Patient Care CDS requiring the application of ICD-10 and OPCS-4 codes, including:

- When the decision to admit is made immediately on the patient presenting to the Emergency Care Department, including when the patient is subsequently taken to an Operating Theatre before ward admission
- When a decision to admit is made but the patient is temporarily accommodated in the Emergency Care Department or elsewhere but remains waiting in the nursing care of the Emergency Care Department for longer than is appropriate for his/her condition before moving to a ward (i.e. a lodged patient).

It is important that this activity data is complete and accurate to avoid inaccuracies or data duplication in CDS flows.

When the patient’s care contact originated as an Emergency Care Department Attendance but there is no evidence when the clinical decision to admit was made, the Health Care Provider will need to find a local solution to ensure this information is recorded. This also triggers the start time for the coding department to apply the codes for Admitted Patient Care CDS data flows.

DATA QUALITY

Medical record

A health record (hereafter referred to as ‘medical record’) is defined in the Data Protection Act 2018 as a record which consists of data concerning health and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates.

It is a medico-legal document and the responsible consultant, or healthcare practitioner, is accountable for the clinical information they record in the medical record. It needs to be complete, accurate, relevant, accessible and timely to the patient's encounter with the health care provider at a given time.

The medical record can be handwritten or digital and may be held in paper or, more commonly electronic format as NHS trusts update and improve their systems to adopt Electronic Patient Records (EPR) systems in hospitals.

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 worksheets, discharge forms, nursing care pathways and diagnostic test reports.

Any of these sources may be accessed for coding purposes. The clinical coder expects to find all relevant clinical information in the medical record and attributed to the relevant episode within the hospital provider spell.

The accuracy, completeness, legibility and timeliness of the information recorded in the medical record is therefore critical to the coding process. As the medical record is the source of truth for the purposes of clinical coding it is recommended that the clinical coder has access to the full medical record in order to extract all relevant information to support the correct assignment of OPCS-4 code(s) to produce consistent, high-quality and comparable data.

The National Clinical Coding Standards cannot provide direction to compensate for deficiencies in the documentation or coding process.

When the medical record does not contain sufficient information to assign a code, the clinical coder must consult the responsible consultant (or their designated representative[1]).

[1] 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.

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

See also: https://www.england.nhs.uk/long-read/high-quality-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 leverage 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.

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.

Further information on information governance can be found at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance

Clinical coding audit

Coded clinical data are audited against National Clinical Coding Standards. Clinical coding audit must be objective and provide value to the local organisation by highlighting and promoting the benefits of taking remedial actions to improve data quality, processes and training 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.

SNOMED CT to OPCS-4 maps

Health care providers that have implemented an EPR system and the clinical terminology SNOMED CT can use the national maps between SNOMED CT UK Edition and OPCS-4. The maps are designed to support those organisations with EPR systems to fulfil the mandatory requirement for collection and reporting of intervention and procedure data using OPCS-4

These maps provide a default OPCS-4 target code and, where appropriate, alternative OPCS-4 target codes. The default OPCS-4 target codes are acceptable for the terminology concept/term to which they are linked. However, where there is more relevant detail within the medical record, the selection of alternative OPCS-4 target codes may need to be undertaken to ensure National Clinical Coding Standards are consistently applied.

The classification maps are compiled by the Terminology and Classifications Delivery Service to reflect the rules and conventions of OPCS-4 as well as these National Clinical Coding Standards.

The major releases of SNOMED CT UK Edition include the OPCS-4 map files which are available for download via the Technology Reference Data Update Distribution (TRUD) service following registration at the following website:
https://isd.digital.nhs.uk/trud/user/guest/group/0/home

Coding Uniformity

Uniformity means that whenever a given procedure performed during an episode is coded, the same code(s) is always used to represent that procedure. Uniformity is essential if the information is to be useful and comparable.

General principles for accurate selection of codes apply:

- Code the minimum number of codes which accurately reflect the patient's interventions/procedure(s) performed during the episode.

- Code each procedure to the furthest level of specificity, i.e. fourth character, which is available in the classification and supported by the clinical information in the medical record.

Three dimensions of coding accuracy

- **Individual codes**

  Each procedure should have the correct code assignment. An individual patient may have many procedures. Consequently, a coded record for an 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 procedures performed during an episode, 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 procedure incorrectly in terms of clinical coding rules and standards even though the individual codes selected are correct.

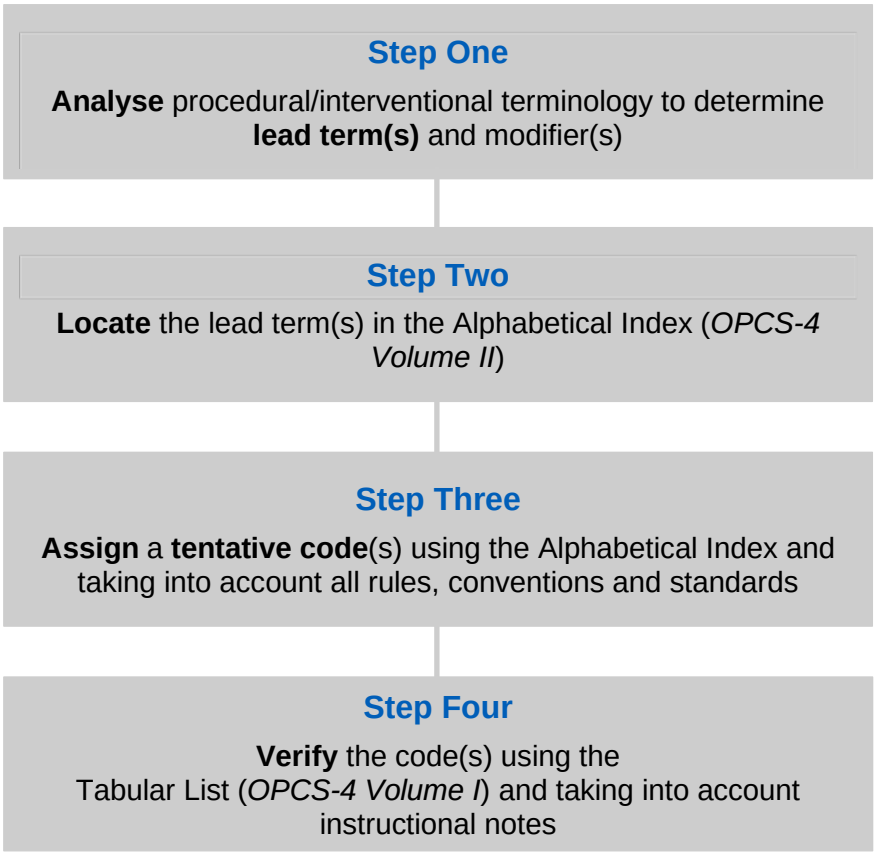
- **Sequencing of codes**

  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 main procedure. ***See PRule 2: Single procedure analysis and multiple coding.***

The four-step coding process

The four staged process that make up the act of coding is designed to ensure appropriate and consistent code assignments. The coder is required to use OPCS-4 Volume II, Alphabetical Index and Volume I, Tabular List and be trained in the use of OPCS-4 and the context in which it is used.

The four-step coding process is the key to ensuring correct use of OPCS-4 and accurate coding of the procedural 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 in training using national core curriculum training materials.



HOW TO USE THIS PUBLICATION

The content is split into distinct sections so that it is clear whether the rule, convention or standard must be applied throughout the classification, or if it should be applied throughout a chapter or if it is specific to a code(s) or procedure.

All rules, conventions and standards 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 reference numbers are specific to each section, as explained below, but all are preceded by the letter '**P**' for 'procedure' to indicate that the rule, convention, or standard is applicable to OPCS-4.

Where there is no section for a chapter this means there are no standards or guidance specific to the chapter, e.g., Chapter F Mouth.

It is important that users understand how each section should be applied when coding.

Supplementary Information for OPCS-4

A separate reference document containing supplementary information about more complex or less well known procedures accompanies these standards. There is a host of reference sources available to coders if they wish to find out how a procedure is performed, such as surgical textbooks, the internet and of course the wealth of knowledge that exists within clinical staff at Trusts. More information on the use of the OPCS-4 Supplementary Information can be found within the document which can be downloaded from the Publications & Resources page on Delen.

Where supplementary information about a procedure within a standard or guidance is available, this will either be identified with a book icon in the title of the standard, e.g.

PCSA4: Cortical mapping (A11.4) 

Or as a blue icon in the top right of the guidance box, e.g.

V02.1 Posterior calvarial release is usually performed as the first stage of a staged procedure and a more substantial remodelling procedure will be performed at a later date. ***See PGCS18: Staged procedures***. 

Rules of the OPCS-4

Rules of the OPCS-4 apply throughout the classification and the clinical coder must be aware of these rules in order to code with consistency and accuracy.

A rule that a coder must comply with is presented in a grey box. Explanatory information about the rule is presented in a white box.

The unique identifiers for rules begin with '**PRule**' and are followed by the number of the rule and the title (e.g., **PRule 7: Subsidiary Chapters Y and Z**).

Conventions of the OPCS-4

Conventions of the OPCS-4 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.

Conventions of the OPCS-4 are presented within a grey box.

The unique identifiers for conventions begin with '**PConvention**' followed by the number of the convention and the title (e.g., **PConvention 2: Instructional notes and paired codes**).

Coding Standards

A coding standard must be applied by the clinical coder in the manner described. 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.

PGCS6: Radical operations
When coding radical operations: • Code assignment must fully reflect the procedure(s) performed during the radical operation • Instructional ***Notes*** must be applied in order to fully reflect all procedures performed • Any uncertainty as to what procedures were performed during the radical operation must be clarified with the responsible consultant in order to ensure correct code assignment.
Radical operations generally involve procedures on multiple sites. This may include the removal of blood supply, lymph nodes and adjacent structures of a diseased organ and is often used in the treatment of malignant neoplasms. Radical operations are generally not listed in the Alphabetical index or the Tabular list of OPCS-4.

There are three types of Standard:

- **General coding standards**

  General coding standards are applicable throughout the classification.

  The unique identifiers for general coding standards begin with '**PGCS**' followed by the number of the standard and the title (e.g., **PGCS2: Diagnostic versus therapeutic procedures**).

- **Chapter standards**

  Chapter standards are located at the beginning of each OPCS-4 chapter and are applicable throughout the chapter. Note that not all chapters will have chapter standards.

  The unique identifiers for chapter standards begin with '**PChS**' followed by the chapter letter, the number of the standard and the title (e.g., **PChSL3: Insertion of stents and stent grafts**).

- **Coding standards**

  Coding standards are located throughout each OPCS-4 chapter and applicable to specific procedures/interventions, codes, categories, or blocks of codes. Coding standards are listed in code, category, or range order.

  The unique identifiers for coding standards begin with '**PCS**' followed by the chapter letter, the number of the standard and the title (e.g., **PCSA1: Guide tube anterior cingulotomy (A03.1)**).

Coding guidance

Coding guidance is advice or information 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 reference numbers or titles. e.g.

Pessaries inserted into the vagina for antiseptic, contraceptive or abortifacient purposes are coded to Chapter Q.

Examples

Examples are included where necessary to illustrate the correct application of a rule, convention or standard and are provided after guidance to illustrate the points made. They are only included when an example of the practical application of codes may aid the coder in understanding the rule, convention or standard. The codes reflect the procedural statement given within the example. Where required a rationale is provided.

Examples are not national standards and should only be used as an aid to coding. Clinical coding must always be based on the information contained within the rule, convention or standard.

Further examples of how standards can be applied can be found in the current ICD-10 and OPCS-4 Exercise and Answer Booklets. These are available to anyone on request via information.standards@nhs.net.

References

References direct the user to a pertinent standard or guidance in a different section. 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.

Parathyroid washout (B16.4)
B16.4 Parathyroid washout is a nuclear medicine imaging procedure and a code from categories **Y93, Y94, Y97** and **Y98** must not be assigned in addition. ***See PCSU3: Nuclear medicine imaging procedures.***

Appendices

The appendices contain additional guidance and information that is not appropriate for inclusion within the main content, for example because it is a long list of guidance or is applicable to multiple chapters.

Index of standards

The Index of standards lists all rules, conventions, general coding standards and chapter standards in the order they appear. It can be used to locate a specific standard.

Summary of Changes

The summary of changes lists each change that has been made between the previous and current release of the National Clinical Coding Standards for OPCS-4 in the order that the change appears. Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated, or deleted.

Updating the National Clinical Coding Standards for OPCS-4

Updated releases of the National Clinical Coding Standards for OPCS-4 may contain new or updated rules, conventions, standards and guidance or they may have been deleted. In each case the updates are made in a consistent manner and are identified in the summary of changes. Users can also refer back to previous versions to see how the standard and codes were applied historically.

New Rules, Conventions and Standards

A new rule, convention, general coding standard and chapter standard is added at the end of the relevant section with a new unique identifier and title.

A new coding standard within a chapter is added in code, category or range order to reflect the location of the code(s) that the standard applies to in the OPCS-4 Tabular List. The new entry is given a new unique identifier and title. This means that the unique identifiers for coding standards within a chapter may not always be listed sequentially.

The unique identifiers and title of all new entries can be referenced in the Index of standards.

Updated rules, conventions and standards

When a rule, convention or standard is updated, the necessary changes are made to the existing text and the unique identifier remains the same.

Deleted Rules, Conventions and Standards

A rule, convention or standard is deleted when it is no longer applicable or has been superseded. Deleted entries are removed.

New, updated and deleted guidance and references

New guidance and references are added in the most relevant location. They are deleted if no longer required. Guidance and references are updated by making the appropriate changes to the existing text of the guidance or reference.

RULES OF OPCS-4

PRule 1: Definition of an intervention

Interventions are those aspects of clinical care carried out on patients undergoing treatment:

- for the prevention, diagnosis, care or relief of disease;
- for the correction of deformity or deficit, including those performed for cosmetic reasons; and
- associated with pregnancy, childbirth or contraceptive or procreative management.

Typically this will be:

- surgical in nature; and/or
- carries a procedural risk; and/or
- carries an anaesthetic risk; and/or
- requires specialist training; and/or
- requires special facilities or equipment only available in an acute care setting.

PRule 2: Single procedure analysis and multiple coding

When a series of operations are recorded, it is traditional, as with diagnostic information, to select the first mentioned for routine analysis.

When classifying diagnostic information, the International Classification of Diseases and Health Related Problems (ICD) recommend criteria for the selection of the MAIN condition for single-cause analysis. OPCS-4 follows this precedent in that the intervention selected for single procedure analysis from records of episodes of hospital care should be the MAIN intervention or procedure carried out during the relevant episode which may not always be the first procedure performed during the consultant episode.

Multiple interventions are often carried out simultaneously. In OPCS-4 some combinations have been encompassed within a single category whilst others, with a seemingly similar relationship, are required to be coded separately. It is important that users of the classification adhere to the instruction notes provided within it to ensure correct selection and sequencing of the codes, ***see PConvention 2: Instructional notes and paired codes*.**

PRule 3: Axis of the classification

There are 24 chapters in total within the OPCS-4 classification. These comprise 20 chapters covering individual body systems (Chapters A–T and V–W), one for diagnostic imaging, testing and rehabilitation procedures (Chapter U) and one for miscellaneous procedures and operations covering multiple systems, e.g. transfusion, resuscitation (Chapter X). There are also two additional chapters providing subsidiary classifications, one for methods of operation (Chapter Y) and the other for sites and laterality of operation (Chapter Z).

The main axis of the classification is body system. Within any particular body system the axis is the organ and within any particular organ the axis is the specific operation/intervention. The operations/interventions are broadly listed in descending order of complexity, e.g. removal, then repair, then aspiration or manipulation, and are generally sequenced in a way which reflects their comparative significance in terms of resource use.

The following guidelines help to identify the level of complexity:

Major	-	Total removal Functional replacement Transplant
Intermediate	-	Partial removal Partial destruction Reconstruction Repair
Minor	-	Biopsy Incision Aspiration
Non-operative procedures	-	Injection Examination Scan/Imaging Screening

In some chapters this major-minor hierarchy principle is either not applicable or not as evident as it should be due to the capacity issues described in ***PRule 5: Capacity, overflow categories and principal and extended categories***.

PRule 4: Category and code structure

Code assignment must always be made to four character level to make the code valid.

The three character category code structure is a three-digit code with an alphabetic character in the first position followed by two numbers. Each three character category is subdivided with four-character codes (subcategories).

The four character code structure is a four-digit code with an alphabetic character in the first position followed by three numbers, with a decimal point before the third number. Four character codes sit within three character categories.

Each four character code identifies a specific method or approach for performing the procedure/intervention mentioned in the three character category title.

Each category is presented in a similar format, and usually includes the provision of a residual subcategory, 'Other specified' **.8**, and an 'Unspecified' **.9** subcategory.

The use of the residual subcategory **.8** follows the axis of the classification within the category and is used when the procedural method to be coded has been specified but is not classified at any of the other four character codes within the category.

For example; for the three character category **C47 Closure of cornea**, the residual subcategory is **C47.8 Other specified closure of cornea** and is assigned for a specified procedural method describing closure of cornea that is not described as a 'Suture', 'Adjustment to suture', 'Removal of suture', or 'Gluing'.

The use of the unspecified subcategory **.9** also follows the axis of the classification within the category and is used when the procedural method to be coded has not been specified and therefore not enough detail has been provided to use any of the other codes (**.1** to **.8**) within the category.

For example; if the procedural method is not specified, and the documentation simply reads 'Closure of Cornea', code **C47.9 Unspecified closure of cornea** would be assigned.

PRule 5: Capacity, overflow categories and principal and extended categories

In order to maintain the structure of the classification **.8** and **.9** codes are available in both principal and the extended categories. Only the **.8** and **.9** codes in the principal category can be used. The **.8** and **.9** codes from the extended category must not be used.

Where a principal category is referred to in an instructional note the extended category must also be referenced. For example:

K22 **Other operations on wall of atrium**
Excludes: Operations on coronary artery (K40-K51) or conducting system of heart (K52, K57, K58)

K57 Other therapeutic transluminal operations on heart is extended at **K62 Therapeutic transluminal operations on heart**, therefore codes in category **K62** are also excluded from **K22**.

The continual revision process naturally introduces some capacity issues as the classification expands.

As a result previous hierarchical body system structure may not be as evident when using OPCS-4. It is therefore imperative that strict use of the Alphabetical Index and Tabular List notes are made when assigning codes.

Where capacity issues arise, the following guidelines are followed:

New three-character categories are placed within chapter ranges, and four-character codes are added to existing categories where space allows. Alternatively, new codes are placed at the end of the specific body system chapter. For example, categories **H01** to **H03** are operations on the appendix, whereas category **H04** relates to operations on the colon and rectum. Therefore, if there is a requirement for a specific operation on the appendix to be included in OPCS-4, and no room exists within the categories **H01–H03**, yet space is available at the end of a chapter, the new code is sited there.

Overflow categories

When additional operations/interventions are required to be classified to that chapter but the chapter is full; overflow categories are created at the end of the chapter. Overflow categories take the same structure as other categories within OPCS-4 but they are assigned the letter O, no matter which chapter they are classified within.

Overflow categories can be found at the end of Chapters L Arteries and Veins, W Other Bones and Joints, Y Subsidiary Classification of Methods of Operation and Z Subsidiary Classification of Sites of Operation. Codes created in this way still form part of an existing

chapter even though they have a different alpha prefix to the rest of the codes within the chapter.

Within the Alphabetical Index codes classified within overflow categories are identified by placing the letter of the chapter the overflow category is contained within in brackets at the end of the index entry, for example **O28.1 Artery Basilar site (Z)**.

Principal and extended categories

There are instances where an existing category is full but additional procedures need to be classified to that category. This is achieved by creating an 'extended category', the category that requires extension becomes a 'principal category'. Navigation is achieved by the inclusion of a cross reference instruction at both three-character category headings of the principal and extended category. For example:

Principal category
E02 Plastic operations on nose
Note: Principal category, extended at E07

Extended category
E07 Other plastic operations on nose
Note: Principal E02

Extended categories are not always in numerical order but have sometimes been slotted into gaps within the classification.

PRule 6: Retired categories and codes

Retired categories and codes must not be used.

Codes fall out of favour for various reasons and there is a mechanism, called retiring, for handling such codes. However, the retirement of a code is only ever considered as a very last option. If an extraordinary circumstance arises where a code/description is considered invalid (usually following classification review), the code, the associated problem, an options appraisal to address it and recommendation(s) are provided to the OPCS-4 Editorial Board for a decision. The support of the relevant professional body would also be required in these circumstances to provide appropriate clinical input.

In practice, the code is retired in the classification with a note to that effect and excluded from the metadata file (used by hospital coding systems) so that it is no longer perpetuated. Additionally, the successor code and the retired code are mapped in the Table of Coding

Equivalence (used to analyse the equivalent codes in the current and previous releases of OPCS-4).

The following categories/codes have been retired from OPCS-4:

G80.2 Code retired - refer to introduction
L99.1 Code retired - refer to introduction
M06.4 Code retired - refer to introduction
M16.4 Code retired - refer to introduction
M28.1 Code retired - refer to introduction
M28.2 Code retired - refer to introduction
M28.3 Code retired - refer to introduction
P15.3 Code retired - refer to introduction
R03 Category retired - refer to introduction
X15.3 Code retired - refer to introduction
X63 Category retired - refer to introduction
X64 Category retired - refer to introduction

PRule 7: Subsidiary Chapters Y and Z

Codes from the subsidiary Chapters **Y Subsidiary Classification of Methods of Operation** and **Z Subsidiary Classification of Sites of Operation** must only ever be coded in a secondary position.

Codes from the subsidiary Chapters **Y Subsidiary Classification of Methods of Operation** and **Z Subsidiary Classification of Sites of Operation** are used to supplement codes from other chapters.

Codes from Chapter Y are used to enhance codes from the body system chapters where this adds further information about the intervention/procedure that cannot be fully reflected by the assignment of the body system code alone.

Codes from Chapter Z are used to define more specifically the site of the operation. Chapter Z also contains codes to identify the laterality of a procedure, e.g. right sided operation, left sided operation and bilateral operation.

Detailed standards on the use of these subsidiary chapters are provided in Chapter Y and Chapter Z.

PRule 8: Surgical eponyms

Section II Alphabetical Index of Surgical Eponyms within Volume II - Alphabetical Index must not be used to assign codes.

Where an eponym is used in the medical record the coder must analyse the procedural information and ensure that code assignment fully reflects the procedure performed.

Where the coder is unsure what procedure the eponym describes, they must seek advice from the responsible consultant to ensure that the correct codes are assigned.

Section II Alphabetical Index of Surgical Eponyms within Volume II - Alphabetical Index of OPCS-4 has been present since OPCS-4.2 and was used to indicate the codes that should be used for various eponyms. The abbreviation (D) at the end of the eponym description denotes device and a bracketed Z code (Z) following the procedure description indicates the necessary site code.

This section has not been revised since 2008 and is only retained for legacy purposes.

A surgical eponym is a procedure either named after the surgeon who pioneered it, or the device used within it. Another surgeon may later adapt the procedure in some way, thereby deviating from the procedure to which the eponym was originally given. The same surgeon, or a different surgeon with the same name, may also develop a different procedure or device which is named after them, resulting in multiple different procedures and devices with the same surgical eponym. This means that some eponyms are listed more than once, with the code given being different in each case because the same eponym describes two different procedures.

It is therefore important, to ensure accurate collection and reporting of data, that eponyms are not used when assigning clinical codes and the coder refers to the procedural information so that code assignment fully reflects the procedure performed.

PRule 9: Surgical abbreviations

Section III Alphabetical Index of Surgical Abbreviations within Volume II – Alphabetical Index must only be used as a guide when coding.

Where an abbreviation is used in the medical record the coder must analyse the procedural information and ensure that code and it’s description fully reflects the procedure performed.

Where the coder is unsure what procedure the abbreviation describes they must seek advice from the responsible consultant to ensure that the correct codes are assigned.

Section III Alphabetical Index of Surgical Abbreviations within the Alphabetical Index contains a short alphabetical index of abbreviations of procedures and interventions. As well as listing the abbreviation itself, this section contains the relevant OPCS-4 code and its description. This list is not exhaustive and does not contain all abbreviations in current usage.

PRule 11: National Tariff Chemotherapy Regimens List

The National Tariff Chemotherapy Regimens List is published to enable the collection, reporting and costing of chemotherapy regimens in the NHS in England.

NHS England has responsibility for the NHS payment system and are responsible for the provision of the National Tariff Chemotherapy Regimens List, which can be downloaded from Delen.

The Chemotherapy Regimens List is an alphabetical list by common regimen abbreviations mapped to an OPCS-4 code for delivery (administration) of the chemotherapy.

As the organisation responsible for the national clinical coding standards and guidance for use within the NHS in England, the Terminology and Classifications Delivery Service have responsibility for the clinical coding standards for use with codes in categories **X70-X73** for the procurement and delivery of chemotherapy for neoplasm and **X74 Other Chemotherapy drugs**.

See:

- ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)***
- ***PCSX28: Route of administration of chemotherapy for neoplasm***
- ***PCSX30: Other chemotherapy drugs (X74)***

CONVENTIONS OF OPCS-4

PConvention 1: Cross references

Cross references are provided in the Alphabetical Index to ensure that all possible terms 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.

See also

This is a reminder to look under another lead term if all the information cannot be found under the first lead term entry.

PConvention 2: Instructional notes and paired codes

Instructional 'Notes' are used within the Tabular list at chapter level, three-character category and four-character code levels. There are three types of notes:

***Includes* notes**

Includes notes clarify the content (intent) of the chapter, category or code to which the note applies, and state what else is included within the chapter, category or code.

***Excludes* notes**

Excludes notes are used to prevent a chapter, category or code from being used incorrectly. They direct the coder away from an incorrect chapter, category or code and direct to the correct place. A specific reference to the correct chapter, category or code is listed in brackets following the exclusion statement.

Note

Notes provide instructions for coding and may be used:

- to advise coders to include or omit additional or subsidiary codes
- to direct coders elsewhere in the classification to more appropriate categories
- to clarify the intended use of a particular chapter, category or code.
- to provide specific instructions on the correct sequencing of codes when used together (**paired codes**)

For guidance on principal and extended categories referenced in instructional notes ***see PRule5: Capacity, overflow categories and principal and extended categories***.

Paired codes notes

Some interventions/procedures are frequently carried out together but are classified at separate codes or categories. Where this is the case the categories concerned contain instructional ***Notes*** to indicate the associated code and correct sequencing.

The following paired codes notes appear in the OPCS-4 Tabular List:

- 'Use **a** supplementary code/Use **an** additional code/Use **a** subsidiary code' - **use the code, at which this note appears in a *primary* position**.
- 'Use **as** a supplementary code/Use **as an** additional code/For use **as a** subsidiary code/Use **as a** secondary code' - **use the code, at which this note appears, in a *secondary* position**.

Paired codes may be classified within the same or a different body system chapter. They can be used alone when only one intervention/procedure is performed.

PConvention 3: Abbreviations

The following abbreviations are used in the Tabular List and the Alphabetical Index:

HFQ (However Further Qualified)

Signifies that a statement may be further qualified/described in a number of ways, which will not affect the code assignment, It refers to the part of the procedural statement that immediately precedes the abbreviation HFQ; it therefore makes no difference how much more specific the clinician is in their statement, there is only one code option for that intervention in OPCS-4.

NEC (Not Elsewhere Classified)

Indicates that a more detailed variation of the term may be covered by another code. Sometimes the more detailed code is found within the same three-character category. If a more detailed code is not available then the NEC code is assigned.

NFQ (Not Further Qualified)

Found in Chapter L, NFQ signifies that the terms 'iliac artery' or 'femoral artery', not further qualified within the code description, should be understood to include the subsites listed in the note at category level.

NOC (Not Otherwise Classifiable)

Is used only in the subsidiary Chapter Y and indicates these methods of operation codes are to be used only when they cannot be specifically coded (i.e. not classified) to any chapter in the main classification.

Two other abbreviations found in the tabular list are the symbols:

> Greater than

< Less than

Examples:

Patient admitted for left sided hemicolectomy and formation of loop ileostomy

H09.4 Left hemicolectomy and ileostomy HFQ

The HFQ applies to the ileostomy. It doesn't matter how the ileostomy is further qualified, i.e. whether it's a loop ileostomy or an end ileostomy, the code is still the same

Patient admitted for endoscopic sphincterotomy of sphincter of Oddi and balloon trawl and removal of calculus

J38.1 Endoscopic sphincterotomy of sphincter of Oddi and removal of calculus HFQ

The HFQ applies to the removal of calculus. It doesn't matter how the removal of the calculus is further qualified; i.e. the calculus could be extracted using a balloon or a basket, the code is still the same

Patient admitted for secondary open reduction and fixation of the right lateral malleolus fracture using extramedullary plate

W23.2 Secondary open reduction of fracture of bone and extramedullary fixation HFQ

The HFQ applies to the extramedullary fixation. It doesn't matter how the fixation device is further qualified, e.g. nail or screw, or in this instance a plate, the code is still the same

GENERAL CODING STANDARDS AND GUIDANCE

PGCS1: Endoscopic and minimal access operations that do not have a specific code

When an endoscopic or minimally invasive procedure (i.e. arthroscopic, thoracoscopic and laparoscopic) is undertaken but no specific code exists to capture this type of approach, dual coding is required. The following codes and sequencing is required:

- Open procedure code
- **Y74–Y77** minimal access approach code
    - When more than one minimally invasive procedure has been undertaken an approach code must be assigned after each open procedure code
- Chapter Y Subsidiary Classification of Methods of Operation code (if required)
- Chapter Z site code(s)
- **Z94.- Laterality of operation** (if applicable)

The Tabular List of the classification includes a range of categories designated as 'endoscopic' procedures, e.g. **M42 Endoscopic extirpation of lesion of bladder**.

When the classification was constructed it was intended that these categories would be primarily used for operations carried out through existing anatomical passages. However, in the past, some of these categories were also expected to be used for operations carried out using minimal incisions through which rigid or fibreoptic scopes are introduced into body cavities, e.g. **Q37 Endoscopic reversal of female sterilisation**.

This practice was maintained in subsequent versions of OPCS-4 and further specific categories were introduced to differentiate between endoscopic and laparoscopic, e.g. **J17.1 Endoscopic ultrasound examination of liver and biopsy of lesion of liver** and **J09.3 Laparoscopic ultrasound examination of liver NEC**.

Examples:

Endonasal endoscopic dacryocystorhinostomy

C25.4 Dacryocystorhinostomy NEC
Y76.6 Endonasal endoscopic approach to other body cavity

Endoscopic primary repair of flexor digitorum profundus (FDP) tendon of left arm using graft

T67.5 Primary repair of tendon using graft
Y76.3 Endoscopic approach to other body cavity
Z56.4 Flexor digitorum profundus
Z94.3 Left sided operation

Arthroscopic (endoscopic) capsulorrhaphy left shoulder

W81.6 Capsulorrhaphy of joint
Y76.7 Arthroscopic approach to joint
Z81.4 Shoulder joint
Z94.3 Left sided operation

Laparoscopic repair of left inguinal hernia using insert of natural material and a laparoscopic repair of umbilical hernia using sutures performed at the same time during the same theatre visit.

T20.1 Primary repair of inguinal hernia using insert of natural material
Y75.2 Laparoscopic approach to abdominal cavity NEC
Z94.3 Left sided operation
T24.3 Repair of umbilical hernia using sutures
Y75.2 Laparoscopic approach to abdominal cavity NEC

Laparoscopic total abdominal hysterectomy with laparoscopic bilateral salpingoophorectomy performed at the same time during the same theatre visit.

Q07.4 Total abdominal hysterectomy NEC
Note: Use a supplementary code for concurrent excision of ovary and/or fallopian tube (Q22-Q24)
Y75.2 Laparoscopic approach to abdominal cavity NEC
Q22.1 Bilateral salpingoophorectomy
Y75.2 Laparoscopic approach to abdominal cavity NEC

Laparoscopic excision of endometriosis of pouch of Douglas.

P31.7 Extirpation of lesion of pouch of Douglas
Y75.2 Laparoscopic approach to abdominal cavity NEC

Laparoscopic deroofing of cyst of the right kidney and laparoscopic denervation of the right kidney.

M04.1 Deroofing of cyst of kidney
Y75.2 Laparoscopic approach to abdominal cavity NEC
M08.2 Open denervation of kidney
Y75.2 Laparoscopic approach to abdominal cavity NEC
Z94.2 Right sided operation

PGCS2: Diagnostic versus therapeutic procedures

If a diagnostic procedure proceeds to, or is performed *at the same time* as, a therapeutic procedure *on the same site* then only the code for the therapeutic procedure is required. This includes:

- diagnostic endoscopies performed prior to an open procedure
- diagnostic endoscopies performed prior to a **therapeutic endoscopic** procedure (as indicated by the instructional ***Notes*** at all therapeutic endoscopic codes).

When a diagnostic (exploratory) laparotomy performed to search for possible pathology progresses to therapeutic procedure(s) as a result of the exploration, only the therapeutic procedure(s) is coded.

There are exceptions to this standard, for example (this is not a definitive list):

- ERCP (**J43**) together with sphincterotomy of sphincter of Oddi (**J38**) or sphincterotomy of accessory ampulla of Vater (**J39**) (as indicated by the ***Note*** at the headings of these categories)
- D&C together with diagnostic hysteroscopy and intrauterine coil (***See PCSQ2: Dilation, curettage (D&C), hysteroscopy and intrauterine coil (Q10.3, Q10.8, Q18.8, Q18.9, Q12)***)
- Therapeutic endoscopic procedures (excluding excisions) with biopsy (***see PGCS10: Coding endoscopic procedures***).

If there is any doubt as to whether a procedure is diagnostic or therapeutic, clarification must be sought from the responsible consultant.

See also PGCS9: Excision and biopsy procedures.

Examples:

Colonoscopy to the descending colon due to rectal bleed reveals a tumour in the descending colon, the surgeon immediately proceeds to left hemicolectomy and end to end anastomosis of colon to rectum.

H09.1 Left hemicolectomy and end to end anastomosis of colon to rectum

Only code the therapeutic procedure because the surgeon proceeded to a therapeutic procedure after a diagnostic procedure on the same site, during the same visit to theatre.

Excision of lesion of skin of the right temple and shave biopsy of lesion of skin of nose during the same visit to theatre.

S06.5 Excision of lesion of skin of head or neck NEC
Z47.2 Skin of temple
Z94.2 Right sided operation
E09.5 Biopsy of lesion of external nose
S14.1 Shave biopsy of lesion of skin of head or neck

Code both the therapeutic and diagnostic procedure as these were performed on two different sites.

Acute abdominal pain. An exploratory laparotomy reveals ruptured right ovarian cyst. Marsupialisation of ovarian lesion performed.

Q43.3 Marsupialisation of lesion of ovary
Z94.2 Right sided operation

Only assign the codes for the marsupialisation of the right ovarian cyst, because the exploratory laparotomy progressed to a therapeutic procedure.

PGCS3: Incomplete, unfinished, abandoned and failed procedures

Abandoned, failed or incomplete procedures (excludes failed procedures converted to open, ***see PGCS4: Failed minimal access and percutaneous transluminal procedures converted to open (Y71.4, Y71.5, Y72.1 and Y72.2)***) must be coded to the stage reached at the abandonment of the procedure; the intention must not be coded. However, if the intervention/procedure reaches the final stage and has been unsuccessful, it must be coded as if the whole procedure has been carried out.

The exception to this standard is ***PCSJ2: Failed or abandoned endoscopic retrograde cholangiopancreatography (J43.9).***

Examples:

Patient admitted for fibreoptic gastroscopy. Procedure abandoned due to obstruction in the oesophagus. Scope could not progress beyond the obstruction

G16.9 Unspecified diagnostic fibreoptic endoscopic examination of oesophagus

Patient with carcinoma stomach admitted for partial gastrectomy. Procedure commenced but carcinoma found to be inoperable

T30.9 Unspecified opening of abdomen
Includes: Exploratory laparotomy NEC

Patient admitted for endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic incision of sphincter of Oddi for removal of bile duct calculus by dormia basket. Extraction attempted, but consultant unable to remove calculus during the procedure

J38.1 Endoscopic sphincterotomy of sphincter of Oddi and removal of calculus HFQ
Note: Use a supplementary code for concurrent diagnostic endoscopic retrograde examination of bile duct and pancreatic duct (J43)

J43.9 Unspecified diagnostic endoscopic retrograde examination of bile duct and pancreatic duct
Includes: Endoscopic retrograde cholangiopancreatography NEC
Note: Use as a supplementary code when associated with endoscopic incision of sphincter of Oddi (J38)

This procedure must be coded as though it has been carried out as it has reached the final stage at time of abandonment.

PGCS4: Failed minimal access and percutaneous transluminal procedures converted to open (Y71.4, Y71.5, Y72.1 and Y72.2)

When a minimal access or percutaneous transluminal approach procedure fails and is converted to an open procedure, during the *same* visit to theatre, the following codes and sequencing must be applied:

- Open procedure code

- **Y71.4 Failed minimal access approach converted to open NEC** or **Y71.5 Failed percutaneous transluminal approach converted to open** or **Y72.1 Failed robotic minimal access approach converted to open** or **Y72.2 Failed video-assisted minimal access approach converted to open**

Examples:

Failed laparoscopic cholecystectomy, converted to an open cholecystectomy

J18.3 Total cholecystectomy NEC
Includes: Cholecystectomy NEC
Y71.4 Failed minimal access approach converted to open NEC

Percutaneous transluminal embolisation of renal artery failed and converted to an open embolisation of renal artery

L42.2 Open embolisation of renal artery
Y71.5 Failed percutaneous transluminal approach converted to open

PGCS5: Unintentional procedures

Where an unintentional action, such as perforation of an organ, occurs during a procedure, this unintentional action must **not** be recorded using OPCS-4 codes.

Any surgical procedures performed to correct the unintentional action, e.g. suture of accidentally perforated organ, must be recorded using the appropriate OPCS-4 code(s).

Any associated diagnosis resulting from the unintentional action, e.g. accidental perforation of organ, will be coded using the appropriate ICD-10 code(s).

Examples:

Patient admitted for excision of their gall bladder, whilst accessing the abdominal cavity the pancreas was accidentally lacerated which was sutured. Successful removal of the gall bladder followed.

J18.3 Total cholecystectomy NEC
J65.8 Other specified other open operations on pancreas
Y25.1 Suture of laceration of organ NOC

Patient taken to theatre for endoscopic endometrial ablation; during an initial hysteroscopy a perforation of the uterus occurs. Laparotomy was performed and a subtotal abdominal excision of the uterus was carried out. Endometrial ablation was not performed.

Q07.5 Subtotal abdominal hysterectomy

PGCS6: Radical operations

When coding radical operations:

- Code assignment must fully reflect the procedure(s) performed during the radical operation
- Instructional ***Notes*** must be applied in order to fully reflect all procedures performed
- Any uncertainty as to what procedures were performed during the radical operation must be clarified with the responsible consultant in order to ensure correct code assignment.

Radical operations generally involve procedures on multiple sites. These may include the removal of blood supply, lymph nodes and adjacent structures of a diseased organ and are often used in the treatment of malignant neoplasms.

Radical operations are generally not listed in the Alphabetical index or the Tabular list of OPCS-4.

Examples:

Radical mastectomy involving total removal of left breast, both pectoral muscles and block dissection of axillary lymph nodes

B27.2 Total mastectomy and excision of both pectoral muscles NEC
Note: Use a supplementary code for removal of lymph node (T85–T87)
Z94.3 Left sided operation
T85.2 Block dissection of axillary lymph nodes
Z94.3 Left sided operation

Radical right nephrectomy with excision of perirenal tissue and adrenal gland

M02.1 Nephrectomy and excision of perirenal tissue
Z94.2 Right sided operation
B22.3 Unilateral adrenalectomy
Z94.2 Right sided operation

PGCS8: Incision as a means of approach

When incisions are made as a means of approach in order to perform further surgery on the site, the incision itself must not be coded.

Examples:

Laparotomy with excision of cyst of left ovary

Q43.2 Excision of lesion of ovary
Z94.3 Left sided operation

PGCS9: Excision and biopsy procedures

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

PGCS10: Coding endoscopic procedures

Diagnostic endoscopic procedures

Where multiple sites are examined during a diagnostic endoscopy, a site code from Chapter Z must be added to identify the furthest site examined (the sites included at each category are indicated at the category *includes* notes).

During a diagnostic endoscopy, if a biopsy is taken at the same time as multiple sites are examined, the site of the biopsy is of greater importance, therefore the site of the biopsy is the only site code required. This includes where the site of biopsy is not the furthest site examined.

Where multiple biopsies are taken, it is only necessary assign a site code for the furthest point biopsied.

Therapeutic endoscopic procedures

The standard in ***PGCS2: Diagnostic versus therapeutic procedures*** applies to therapeutic endoscopic procedures with the exception of therapeutic endoscopic procedures (that is not an excision) together with biopsy.

When a therapeutic endoscopic procedure is performed and a biopsy is taken at the same time, the following codes and sequencing must be applied:

- Therapeutic body system endoscopy code
- Chapter Z site code(s) (if the therapeutic endoscopy code does not state the specific site of the procedure and where the specific site of the biopsy is different to the therapeutic endoscopy)
- **Y20 Biopsy of organ NOC***
- Chapter Z site code (for the site of the biopsy)

* When an endoscopic excision is performed and a biopsy is taken at the same time, the biopsy must only be coded if it is taken from a **different site** (with different site code) to the excision, ***See PGCS9: Excision and biopsy procedures***.

Where multiple excisions, using the same method, have been performed, site codes must be assigned for each site of excision (the sites included at each category are indicated at the category *includes* notes).

When other sites have been passed in order to arrive at the point of the actual therapeutic endoscopic procedure the assumption is that all the sites en route to the point of the procedure are examined and therefore must not be identified separately.

Multiple simultaneous therapeutic endoscopic procedures

Where multiple therapeutic methods/techniques are used during an endoscopic procedure, (e.g. laser destruction and snare resection), a body system code for each method must be assigned followed by the relevant site code(s).

Additional codes from Chapter Y may be assigned where this adds further information. ***See also PChSY1: Use of codes in Chapter Y.***

Where multiple therapeutic methods/techniques are classified using multiple body system codes, and a biopsy is taken at the same time, a code from **Y20 Biopsy of organ NOC** is assigned following any of the body system codes. Where one of these procedures is an excision the biopsy must only be coded if performed on a different site to the excision.

There are two types of endoscopic procedures:

Diagnostic -	the endoscope is used to examine the organ in order to determine the nature of the disease
Therapeutic -	the endoscope is used to administer some form of treatment for the disease.

The ‘endoscopy NEC’ default in OPCS-4 is fibreoptic (flexible) as this accurately reflects clinical practice, i.e. where the type of endoscope has not been stated, the classification defaults the coder to a fibreoptic category.

Examples:

Endoscopic examination of gastrointestinal tract to pylorus

G45.9 Unspecified diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract
Includes: Diagnostic endoscopic examination of upper gastrointestinal tract NEC
Oesophagus
Stomach
Pylorus
Proximal duodenum
Note: Use a subsidiary site code as necessary
Z27.3 Pylorus

Endoscopic examination of trachea, bronchus and lung with biopsy of trachea

E49.1 Diagnostic fibreoptic endoscopic examination of lower respiratory tract and biopsy of lesion of lower respiratory tract
Includes: Diagnostic endoscopic examination of lower respiratory tract NEC
Trachea
Carina
Bronchus
Lung
Note: Use a subsidiary site code as necessary
Z24.3 Trachea

Fibreoptic endoscopic examination of upper gastrointestinal tract with biopsies of oesophagus and stomach

G45.1 Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract
Includes: Diagnostic endoscopic examination of upper gastrointestinal tract NEC
Oesophagus
Stomach
Pylorus
Proximal duodenum
Note: Use a subsidiary site code as necessary
Z27.2 Stomach

Fibreoptic endoscopy to stomach with removal of foreign body from oesophagus and biopsy of oesophagus

G44.2 Fibreoptic removal of foreign body from upper gastrointestinal tract
Includes: Therapeutic endoscopic operations on upper gastrointestinal tract NEC
Oesophagus
Stomach
Pylorus
Proximal duodenum
Note: Use a subsidiary site code as necessary
Y20.9 Unspecified biopsy of organ NOC
Z27.1 Oesophagus

Fibreoptic endoscopic removal of foreign body from trachea and biopsy of lung

E48.5 Fibreoptic endoscopic removal of foreign body from lower respiratory tract
Includes: Therapeutic endoscopic operations on lower respiratory tract NEC
Trachea
Carina
Bronchus
Lung
Note: It is not necessary to code additionally any mention of diagnostic fibreoptic endoscopic examination of lower respiratory tract (E49.9)
Note: Use a subsidiary site code as necessary
Z24.3 Trachea
Y20.9 Unspecified biopsy of organ NOC
Z24.6 Lung

Colonoscopy with snare excision of lesions of caecum, and biopsy of transverse colon

H20.1 Fibreoptic endoscopic snare resection of lesion of colon
Includes: Endoscopic extirpation of lesion of lower bowel NEC
Large Intestine
Rectum
Note: Use a subsidiary site code as necessary
Z28.2 Caecum
Y20.9 Unspecified biopsy of organ NOC
Z28.4 Transverse colon

Sigmoidoscopy with snare resection of lesion of sigmoid colon and biopsy of lesion of sigmoid colon:

H23.1 Endoscopic snare resection of lesion of lower bowel using fibreoptic sigmoidoscope

Includes: Colon
Rectum

Note: Use a subsidiary site code as necessary

Z28.6 Sigmoid colon

Fibreoptic endoscopic cauterisation of lesion of the pylorus. The oesophagus and stomach are examined en route.

G43.3 Fibreoptic endoscopic cauterisation of lesion of upper gastrointestinal tract

Includes: Endoscopic extirpation of lesion of upper gastrointestinal tract NEC
Oesophagus
Stomach
Pylorus
Proximal duodenum

Note: Use a subsidiary site code as necessary

Z27.3 Pylorus

Colonoscopy with snare excision of lesions from caecum, transverse and sigmoid colon

H20.1 Fibreoptic endoscopic snare resection of lesion of colon

Includes: Caecum
Mucosa of colon
Mucosa of caecum

Note: Use a subsidiary site code as necessary

Z28.2 Caecum
Z28.4 Transverse colon
Z28.6 Sigmoid colon

Fibreoptic endoscopic snare resection of lesion of trachea and laser destruction of lesion of lung

E48.1 Fibreoptic endoscopic snare resection of lesion of lower respiratory tract
Includes: Therapeutic endoscopic operations on lower respiratory tract NEC
Trachea
Carina
Bronchus
Lung
Note: It is not necessary to code additionally any mention of diagnostic fibreoptic endoscopic examination of lower respiratory tract (E44.9)
Note: Use a subsidiary site code as necessary
Z24.3 Trachea
E48.2 Fibreoptic endoscopic laser destruction of lesion of lower respiratory tract
Z24.6 Lung

Endoscopic fibreoptic submucosal resection and cauterisation of lesions of transverse colon performed at the same time

H20.5 Fibreoptic endoscopic submucosal resection of lesion of colon
Includes: Endoscopic extirpation of lesion of lower bowel NEC
Large Intestine
Rectum
Note: Use a subsidiary site code as necessary
Z28.4 Transverse colon
H20.2 Fibreoptic endoscopic cauterisation of lesion of colon
Z28.4 Transverse colon

Colonoscopy with Argon Plasma Coagulation (APC) of lesion of transverse colon, submucosal resection (SMR) of descending colon and transverse colon polyps and biopsy of lesions of ascending colon

H20.2 Fibreoptic endoscopic cauterisation of lesion of colon
Includes: Endoscopic extirpation of lesion of lower bowel NEC
Large Intestine
Rectum
Note: Use a subsidiary site code as necessary
Y17.1 Electrocauterisation of lesion of organ NOC
Z28.4 Transverse colon
H20.5 Fibreoptic endoscopic submucosal resection of lesion of colon
Z28.5 Descending colon
Z28.4 Transverse colon
Y20.3 Biopsy of lesion of organ NOC
Z28.3 Ascending colon

Where multiple therapeutic methods/techniques are classified using multiple body system codes, and a biopsy is taken at the same time, a code from **Y20 Biopsy of organ NOC** can be assigned following any of the body system codes.

PGCS11: Coding procedures performed for the correction of congenital deformities

When coding procedures performed for the correction of congenital deformities the following apply:

- If the Chapter X code can be directly index trailed from the OPCS-4 Alphabetical Index (Volume II), then the Chapter X code **must** be used.
- If a code that more accurately reflects the procedure can be found elsewhere within the main body system Chapters (A–W), the code(s) from the main body system chapter(s) must be used, unless there is a specific instruction to do otherwise.
- The coder must ensure that the codes assigned fully and accurately describe the procedure(s) performed and it may, therefore, be appropriate to seek advice from the responsible clinician.

Certain procedures performed to correct congenital deformities are classified within Chapter X and Chapter W of OPCS-4. The Chapter X codes for the correction of congenital deformities are very specific and encompass the diagnosis for which the procedure is being carried out within the category title.

The '***Excludes***' notes which exist at some categories in Chapter W state that '*some similar operations for correction of congenital deformity*' are classified in Chapter X. These notes

do not indicate that a code from Chapter X must always be used when coding a procedure for the correction of a congenital condition.

When coding procedures performed for the correction of congenital deformities the ICD-10 diagnosis code is used as a parameter to confirm the fact that the deformity is congenital.

Examples:

Separation of tarsal coalition of left foot.

X25.4 Separation of tarsal coalition
Z94.3 Left sided operation

The OPCS-4 Alphabetical Index (Volume II) specifically directs to code **X25.4 Separation of tarsal coalition**.

Second stage tendo-achilles tenotomy and resiting of wire proximal ring of Ilizarov fixator (inserted at 1st stage) of right foot for correction of congenital clubfoot.

T70.2 Tenotomy NEC
Y71.1 Subsequent stage of staged operations NOC
Z58.1 Triceps surae
W30.2 Adjustment to external fixation of bone NEC
Z80.9 Bone of foot NEC
Z94.2 Right sided operation

The OPCS-4 Alphabetical Index (Volume II) directs the coder directly to OPCS-4 codes outside of Chapter X. These codes more accurately reflect the procedure than codes within Chapter X.

PGCS12: Coding grafts and harvests of sites other than skin

Grafts (other than skin grafts) must be coded as follows:

Autografts (graft using material harvested from patient):

- Body system chapter code classifying the organ/site being grafted*****
- **Y36.5 Introduction of biological scaffold into organ NOC** or **Y36.6 Introduction of synthetic scaffold into organ NOC** or **Y36.7 Introduction of other scaffold into organ NOC** (if a scaffold was used)

- Chapter Z site code identifying the specific site/organ being grafted (if this has not already been identified within the body system code)
- **Z94.- Laterality of operation** (if applicable)
- Chapter Y code identifying the type of tissue harvested and the site of harvest (unless this is identified within the body system code)
- Chapter Z site code identifying the site of the harvest (if this has not already been identified within the Y harvest code)
- **Z94.- Laterality of operation** (if applicable).

*****Even if the body system code description does not contain the term 'graft' it is not necessary to assign a code from **Y27.- Graft to organ NOC,** as the graft is implied with the assignment of the harvest code.

Other types of graft (grafts using material not harvested from patient, including allograft, xenograft and prosthetic graft):

- Body system chapter code classifying the organ/site being grafted
- **Y27.- Graft to organ NOC** if a graft and/or the material used has not been identified within the body system code
- **Y36.5 Introduction of biological scaffold into organ NOC** or **Y36.6 Introduction of synthetic scaffold into organ NOC** or **Y36.7 Introduction of other scaffold into organ NOC** (if a scaffold was used)
- Chapter Z site code identifying the specific site/organ being grafted (if this has not already been identified within the body system code)
- **Z94.- Laterality of operation** (if applicable).

An additional harvest code must not be assigned.

The exception to this standard is ***PCSW4: Total hip replacement with acetabular bone graft (W37-W39)***.

See also:

- ***PCSS3: Coding skin grafts and harvests***
- ***PCSW3: Harvest of bone marrow for autologous transplant (W35.8)***
- ***PCSW14: Implantation of stem cells into joint***
- ***PCSX12: Donation of skin (X46.2)***
- ***PCSY12: Donor status (Y99)***

Examples:

Primary graft to right femoral nerve. Patient's right sural nerve harvested.

A63.1 Primary graft to peripheral nerve NEC
Z10.1 Femoral nerve
Z94.2 Right sided operation
Y54.1 Harvest of sural nerve
Z94.2 Right sided operation

Autograft bone from left iliac crest to right radius

W31.9 Unspecified other autograft of bone
Z70.9 Radius NEC
Z94.2 Right sided operation
Y66.3 Harvest of bone from iliac crest
Z94.3 Left sided operation

Left tympanoplasty using left tragus graft

D14.1 Tympanoplasty using graft
Z94.3 Left sided operation
Y69.2 Harvest of cartilage from ear
Z94.3 Left sided operation

Endoscopic total replacement of right meniscus using allograft from cadaver

W82.4 Endoscopic total replacement of meniscus of knee joint
Y01.6 Alloreplacement of organ from cadaver NOC
Z94.2 Right sided operation

Bypass of one coronary artery using saphenous vein graft

K40.1 Saphenous vein graft replacement of one coronary artery

Endoscopic myringoplasty of left ear using prosthetic graft

D14.1 Tympanoplasty using graft
Y76.3 Endoscopic approach to other body cavity
Y27.6 Prosthetic graft NOC
Z94.3 Left sided operation

PGCS14: Sequencing of codes in Chapter Y with codes in Chapter Z
When assigning codes from both **Chapter Y Subsidiary Classification of Methods of Operation** and **Chapter Z Subsidiary Classification of Sites of Operation** the Chapter Y code must precede the Chapter Z code.

PGCS15: Emergency procedures
When deciding which category to assign, the nature of the *procedure* and not the nature of the *admission* must be taken into account. The term *emergency* pertains to the use of operating theatre time that has not been pre-scheduled (including operations added to a pre-scheduled list). If there is any doubt, the coder must seek advice from the responsible consultant
Separate categories exist within **Chapter H Lower Digestive Tract, Chapter L Arteries and Veins** and **Chapter R Female Genital Tract Associated with Pregnancy, Childbirth and Puerperium** to classify emergency and other excision of appendix (Chapter H) or emergency and other replacement/bypass of artery (Chapter L) or elective and other caesarean delivery (Chapter R).

Example:

Patient admitted from outpatient clinic with large infrarenal abdominal aortic aneurysm. Added to that afternoon's surgical theatre list for a replacement of aneurysmal segment by anastomosis of aorta to aorta.

L18.4 Emergency replacement of aneurysmal segment of infrarenal abdominal aorta by anastomosis of aorta to aorta

The terms **revision** and **revisional** are used to allow discrimination between subsequent operations on the *same* site usually to correct or remove a problem arising since the original surgery, and operations of a primary nature with the same name. Procedures which involve the use of a prosthesis are only considered a revision where this is a 'like for like' procedure.

Examples:

Replacement of an uncemented left Freeman total hip replacement with an uncemented Monk prosthesis

W38.3 Revision of total prosthetic replacement of hip joint not using cement
Z94.3 Left sided operation

This is a like for like procedure because the uncemented prosthesis is replaced with another uncemented prosthesis, it is therefore coded as a revision.

Revisional septoplasty of the nose

E03.6 Septoplasty of nose NEC
Y71.3 Revisional operations NOC

PGCS16: Conversion procedures

‘Conversion to’ and ‘Conversion from’ codes must always be:

- sequenced with the ‘Conversion to’ code preceding the ‘Conversion from’ code
- used together, except where there is a note indicating that a code not specifically described as a ‘conversion to’ or conversion from’ can be used
- assigned from *different* three-character categories.

‘Conversion’ procedures relate to the dismantling of a particular type of operation and the introduction of a ‘new’ and ‘different’ procedure on the same site.

The new procedure is coded as a ‘conversion to’ procedure. The ‘conversion from’ code, always ends in **.0**, and represents the previous procedure being dismantled.

Conversion codes can be found at Chapters G and W.

Examples:

Conversion to left total hip replacement (THR) using cement from a previous uncemented THR.

W37.2 Conversion to total prosthetic replacement of hip joint using cement
Note: Use a subsidiary conversion from code as necessary
W38.0 Conversion from previous uncemented total prosthetic replacement of hip joint
Z94.3 Left sided operation

Conversion from a direct anastomosis of oesophagus to a bypass of oesophagus by interposition of jejunum.

G05.4 Bypass of oesophagus by interposition of jejunum NEC
G06.0 Conversion from previous direct anastomosis of oesophagus
Note: For use as a subsidiary code when associated with construction of interposition anastomosis of oesophagus (G05)

The term **secondary** is used to identify a repeated procedure on the *same* site. It may identify a secondary treatment/procedure which is different from the original, but which is performed for the same purpose as the original procedure.

See also PCSW1: Secondary reduction and remanipulation of fracture and fracture dislocation.

Example:

Secondary repair of right extensor hallucis longus tendon using lengthening procedure

T68.2 Secondary repair of tendon using lengthening procedure
Z58.5 Extensor hallucis longus
Z94.2 Right sided operation

PGCS17: Maintenance and attention to procedures
A supplementary code from Chapter Y must be added in addition to the maintenance/attention to code, when doing so provides additional information.
Maintenance and attention to codes are used when a further procedure is carried out on an existing procedure that cannot be classified to a dedicated code within that category. A supplementary code from Chapter Y must be added in addition to the attention to/maintenance code, when doing so provides additional information.

Examples:

Resiting of urethral catheter in bladder

M47.5 Maintenance of urethral catheter in bladder
Y03.4 Other resiting of prosthesis in organ NOC

Correction of displaced right cochlear prosthesis:

D24.3 Attention to cochlear prosthesis
Y03.3 Correction of displacement of prosthesis NOC
Z94.2 Right sided operation

PGCS18: Staged procedures

When coding staged procedures, if a specific code describing the staged procedure is not available one of the following codes must be assigned as an additional code to indicate the stage of the procedure:

Y70.3 First stage of staged operations NOC
Y71.1 Subsequent stage of staged operations NOC

Some procedures are performed in planned separate stages where the patient undergoes the first stage of the procedure during one visit to theatre and then undergoes the second and subsequent procedure(s) at a later date. Specific codes are available in some of the body system chapters that classify procedures that are commonly performed in separate stages e.g. **D05.1 First stage insertion of fixtures for auricular prosthesis**, **E11.3 Second stage attachment of fixtures for nasal prosthesis**, **N08.3 First stage bilateral orchidopexy** etc. Not all procedures that can be performed in stages have dedicated staged procedure codes.

Examples:

Patient admitted for first stage of a two stage repair of cleft palate

F29.1 Primary repair of cleft palate
Y70.3 First stage of staged operations NOC

Patient admitted for second stage of repair of cleft palate

F29.1 Primary repair of cleft palate
Y71.1 Subsequent stage of staged operations NOC

PGCS19: Temporary operations

Where a temporary operation is performed and a specific temporary operation code does not exist, code **Y70.5 Temporary operations** must be assigned in a secondary position.

Code **Y44.3 Temporary occlusion of organ NOC** must be used in preference to **Y70.5** if an organ is temporarily occluded.

Various codes exist within OPCS-4 which specifically classify a temporary operation, for example:

G74.2 Creation of temporary ileostomy
X42.1 Insertion of temporary peritoneal dialysis catheter

Example:

Temporary implantation of intravenous single chamber pacemaker under fluoroscopic control

K60.5 Implantation of intravenous single chamber cardiac pacemaker system
Y53.4 Approach to organ under fluoroscopic control
Y70.5 Temporary operations

PGCS20: Procedures performed for haemostasis

When coagulation and/or cauterisation is performed as a means of haemostasis following the extirpation of a lesion, then the cauterisation/coagulation must not be coded in addition.

See also

- ***PCSY1: Argon plasma coagulation (Y10.2 and Y17.1)***
- ***PCSM12: Cystoscopy with cystodiathermy***

Haemostasis is the mechanism that leads to cessation of bleeding from a blood vessel. It can be achieved through systemic or topical approaches.

Coagulation (or clotting) is the process through which blood changes from a liquid to a gel, becoming thicker and clotting. There are various surgical methods which may be used for coagulation therapy or to achieve haemostasis at the end of a procedure: for example, the application of a haemostatic spray or cauterisation.

Examples:

Endoscopic fibreoptic coagulation of a bleeding lesion in the oesophagus using haemostatic spray

G20.2 Fibreoptic endoscopic coagulation of bleeding lesion of oesophagus using haemostatic spray

Endoscopic fibreoptic submucosal resection of gastric polyp. Post-excisional bleeding halted and haemostasis achieved by endoscopic fibreoptic coagulation of the affected area

G42.1 Fibreoptic endoscopic submucosal resection of lesion of upper gastrointestinal tract
Z27.2 Stomach

Enhancing body system codes using codes from Chapter S

Codes from Chapter S may be used to enhance codes from other body system chapter. ***See PChSS1: Enhancing body system codes using codes from Chapter S.***

Coding diagnostic imaging procedures classified outside of Chapter U

When a specific code classifying a diagnostic imaging procedure is available in a body system chapter (Chapters A-T and V–W) the body system chapter code **must** be used in preference to the codes within categories **U01–U21** and **U35–U37**.

See PCSU1: Diagnostic imaging procedures (U01–U21 and U35–U37)

Coding radiotherapy using body system chapter codes

When a code classifying radiotherapy is available within a body system chapter this must be sequenced before a code from category **X65 Radiotherapy delivery**. ***See PCSX20: Radiotherapy (X65, X67–X69).***

Approach to organ (Y45–Y52, and Y74-Y77)

See PCSY6: Approach to organ (Y45–Y52 and Y74-Y77)

Approach to organ under image control (Y53, Y68 and Y78)
See PCSY7: Approach to organ under image control (Y53, Y68 and Y78)

Site codes
See PCSZ1: Site codes

Laterality of operation (Z94)
See PCSZ2: Laterality of operation (Z94)

CHAPTER A NERVOUS SYSTEM
(A01–A84)

Coding standards and guidance

PCSA1: Guide tube anterior cingulotomy (A03.1)

The following codes and sequencing must be used for a guide tube anterior cingulotomy when performed using radiofrequency energy under magnetic resonance image control:

A03.1 Stereotactic leucotomy
Y47.- Burrhole approach to contents of cranium
Y11.4 Radiofrequency controlled thermal destruction of organ NOC
Y53.7 Approach to organ under magnetic resonance imaging control
Z01.7 Cingulate gyrus

PCSA2: Pain relief procedures

Procedure		OPCS-4 code(s)
Block, brachial plexus		**A73.5 + Z08.9**
Block, caudal	- long acting pain relief - destructive	**A52.2** **A54.1**
Block, cervical plexus	- long acting pain relief - destructive	**A73.5** **A60.5**
Block, coeliac plexus	- long acting pain relief - destructive, chemical - destructive, cryotherapy - destructive, radiofrequency - destructive NEC	**A81.2** **A76.5** **A77.5** **A78.5** **A79.5**
Block, dorsal root ganglion nerve	- destructive NEC - destructive, radiofrequency - destructive, chemical	**A57.5 + Z07.-** **A57.3 + Z07.-** **A57.4 + Z07.-**
Block, facet joint		**V54.4 + V55.- + Z67.-**

Block, guanethidine	- long acting pain relief - destructive	**A81.2** **A76.-**
Block, intercostal nerve	- long acting pain relief	**A73.5 + O52.1**
Block, medial branch		**A73.5 + O42.-**
Block, peripheral nerve root	- pain relief	**A73.5 + site**
Block, pudendal	- long acting pain relief	**A73.5 + Z11.3**
Block/blockade, stellate ganglion	- long acting pain relief - destructive, chemical - destructive, cryotherapy - destructive, radiofrequency - destructive	**A81.1** **A76.8 + Z92.3** **A77.8 + Z92.3** **A78.8 + Z92.3** **A79.8 + Z92.3**
Block, sympathetic nerve	- long acting pain relief - destructive, chemical - destructive, cryotherapy - destructive, radiofrequency - destructive NEC	**A81.2** **A76.-** **A77.-** **A78.-** **A79.-**
Block, trigeminal nerve	- long acting pain relief - destructive	**A36.5** **A26.3**
Cryoprobe peripheral nerve lesion		**A61.2 + site**
Denervation, trigeminal nerve	- pain relief - destructive	**A36.5** **A26.3**
Denervation, medial branch nerve	- pain relief	**V48.- + V55.-**
Destruction spinal nerve, radiofrequency controlled, thermal		**A57.3**
Epidural, for pain relief	- dorsal, cervical, thoracic - lumbar - sacral	**A52.8 + Z06.-** **A52.1** **A52.2**
Intrathecal pump	- implant - refilling - removal	**A54.3** **A54.4 + Y03.1** **A54.5**
Neurodestruction	- peripheral nerve - sympathetic nerve	**A60.5 + site** **A76.-**

Stimulator/neurostimulator dorsal column	**A48.3 + Z06.2**

PCSA3: Neurostimulators (A09, A33, A48 and A70)

When a neurostimulator is permanently implanted under the skin the following codes and sequencing are applied:

- Code that classifies the implantation of neurostimulator
- Chapter Z site code, where this adds additional information
- **Z94.- laterality of operation** (if applicable)

When electrode leads are implanted temporarily to test whether the intervention is likely to be effective and the pulse generator device is not implanted under the skin the following codes and sequencing are applied:

- Code that classifies insertion of neurostimulator electrodes
- **Y70.5 Temporary operations**
- Chapter Z site code, where this add further information
- **Z94.- laterality of operation** (if applicable)

Example:

Temporary insertion of right sacral nerve neurostimulator electrodes.

A70.4 Insertion of neurostimulator electrodes adjacent to peripheral nerve
Y70.5 Temporary operations
Z11.2 Sacral nerve
Z94.2 Right sided operation

Transcutaneous stimulation of the cervical branch of the vagus nerve:

A70.7 Application of transcutaneous electrical nerve stimulator
Z04.4 Vagus nerve (x)

PCSA8: Stereotactic radiosurgery of cranial nerves and intracranial arteriovenous malformation (A10.7)

A10.7 Stereotactic radiosurgery on tissue of brain must be assigned as the body system chapter radiotherapy code for stereotactic radiosurgery on cranial nerves or intracranial arteriovenous malformation (AVM).

See also ***PCSX20: Radiotherapy (X65, X67–X69)***
A10.7 is required to ensure these procedures are grouped into the correct HRG.

Example:

Stereotactic radiosurgery using external beam megavoltage treatment for trigeminal neuralgia

A10.7 Stereotactic radiosurgery on tissue of brain
Note: Use an additional code to specify radiotherapy delivery (X65)
X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.1 Megavoltage treatment for complex radiotherapy
Z03.5 Trigeminal nerve (v)

PCSA4: Cortical mapping (A11.4)

Cortical mapping can take several hours over a number of days. It must only be coded once per hospital provider spell as follows:

- Assign the following codes according to the type of electrodes that have been placed:

  A11.1 Placement of depth electrodes for electroencephalography
  Y47.- Burrhole approach to contents of cranium (if performed using this approach)
  or
  A11.2 Placement of surface electrodes for electroencephalography
  Y46.- Open approach to contents of cranium (if performed using this approach)

- Assign code **A11.4 Cortical mapping** directly afterwards.

When cortical mapping is performed during a procedure on the brain when the patient is awake (e.g. excision of a brain lesion) code **A11.4** must be assigned in addition to the codes that classify the procedure on the brain.

PCSA5: Electroconvulsive therapy (A83)

Each individual treatment within a course of electroconvulsive therapy (ECT) must be recorded separately.

- For the first administration within a course of therapy assign code **A83.8 Other specified electroconvulsive therapy** in the primary position
    - Where a number of courses have been administered during the same consultant episode, all instances of **A83.8** must be assigned before assigning **A83.9**
- For subsequent administrations in the same course of therapy (whether in the same consultant episode within a hospital provider spell or a subsequent hospital provider spell) code **A83.9 Unspecified electroconvulsive therapy** must be assigned.

Patients undergoing ECT are usually given a course of therapy which involves a number of treatments. Subsequent treatments within a course may be given during the same hospital provider spell as the first treatment or during a subsequent hospital provider spell(s).

Examples:

Administration of first treatment in a course of electroconvulsive therapy. Second and third treatments administered within the same hospital provider spell.

A83.8 Other specified electroconvulsive therapy
A83.9 Unspecified electroconvulsive therapy
A83.9 Unspecified electroconvulsive therapy

Administration of fourth treatment in a course of electroconvulsive therapy.

A83.9 Unspecified electroconvulsive therapy

Administration of two courses of ECT, each course consisting of two treatments during one consultant episode.

A83.8 Other specified electroconvulsive therapy
A83.8 Other specified electroconvulsive therapy
A83.9 Unspecified electroconvulsive therapy
A83.9 Unspecified electroconvulsive therapy

Standard EEG (**A84.1 Electroencephalography NEC**) is usually performed in outpatients and can last up to about an hour. It uses simultaneous video to allow the reporting clinician to visualise any attacks or seizures occurring during the test. ***See also PCSU5: Diagnostic tests (U22-U33 and U40-U41) for guidance on Electroencephalograph telemetry (U22.1).***

Codes within the range **A38**-**A43** must not be used to classify procedures on the spinal dura, as these categories classify procedures on the meninges of the brain only.

PCSA6: Evoked potential recording (A84.4)

A84.4 Evoked potential recording must be coded whenever it has been documented to have been carried out.

Code **A84.7 Sleep studies NEC** includes a '*full polysomnography*'. A full polysomnography will include electroencephalography (EEG), electrooculography (EOG), and surface electromyography (EMG).This code includes multiple sleep latency tests (MSLT) and the maintenance of wakefulness tests (MWT). These sleep studies are carried out by specialists in Neurosciences and the emphasis will be on the diagnosis of disorders of sleep pattern and not solely for diagnosis of disorders of breathing. ***See also Chapter U for guidance on polysomnography (U33.1).***

CHAPTER B ENDOCRINE SYSTEM AND BREAST (B01–B45)

Chapter standards and guidance

Operations on the skin of the breast are classified to Chapter S. The skin of the nipple and areola, however, are classified to this chapter.

Coding standards and guidance

PCSB1: Pituitary excision with skull base reconstruction

When pituitary excision or excision of a pituitary lesion is performed using endonasal endoscopic trans-sphenoidal approach, and an anterior skull base reconstruction is performed (the defect created in the anterior skull base by the approach is closed using a mucosal flap to the nasopharynx), the following codes and sequencing must be assigned:

Pituitary excision code
Y76.6 Endonasal endoscopic approach to other body cavity
E15.8 Other specified operations on sphenoid sinus
Y76.6 Endonasal endoscopic approach to other body cavity
Y26.1 Reconstruction of organ NOC
S28.8 Other specified flap of mucosa
Y76.6 Endonasal endoscopic approach to other body cavity
Z22.6 Nasopharynx

See *PGCS1: Endoscopic and minimal access operations that do not have a specific code.*

It is strongly recommended that where hypophysectomy (partial or total excision of pituitary gland) is documented, coders liaise with the responsible consultant to confirm that the actual procedure performed was hypophysectomy and not an excision of pituitary lesion, to ensure the appropriate code is assigned.

Total excision of the pituitary gland is no longer performed within the NHS, and although partial excision of the pituitary gland is still performed, it is rare.

Example:

Excision of pituitary tumour and anterior skull based reconstruction with mucosal flap. All performed using endonasal endoscopic trans-sphenoidal approach.

B04.1 Excision of lesion of pituitary gland
Y76.6 Endonasal endoscopic approach to other body cavity
E15.8 Other specified operations on sphenoid sinus
Y76.6 Endonasal endoscopic approach to other body cavity
Y26.1 Reconstruction of organ NOC
S28.8 Other specified flap of mucosa
Y76.6 Endonasal endoscopic approach to other body cavity
Z22.6 Nasopharynx

Parathyroid washout (B16.4)

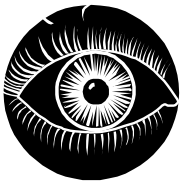
B16.4 Parathyroid washout is a nuclear medicine imaging procedure and a code from categories **Y93, Y94, Y97** and **Y98** must not be assigned in addition.

See PCSU3: Nuclear medicine imaging procedures

PCSB3: Evacuation of post-operative haematoma from breast

Evacuation of post-operative haematoma from the breast must be classified using the following OPCS-4 codes:

B33.1 Drainage of lesion of breast
Y22.1 Aspiration of haematoma of organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control** (if applicable)
Z94.- Laterality of operation



CHAPTER C EYE
(C01–C91)

Chapter standards and guidance

PChSC1: Minimally invasive glaucoma surgery (MIGS)
When a procedure is documented as a MIGS procedure **Y76.9 Unspecified minimal access to other body cavity** must be assigned following the appropriate code for the procedure performed. ***See also PCSY6: Approach to organ (Y45–Y52 and Y74-Y77)***
It is strongly recommended that coding managers work closely with the relevant Ophthalmologists within their trust to ensure that MIGS procedures and devices are clearly documented within the medical record to ensure the accurate assignment of codes.

Example:

Insertion of MIGS aqueous humour drainage tube into right eye for open angle glaucoma

C60.5 Insertion of tube into anterior chamber of eye to assist drainage of aqueous humour
Y76.9 Unspecified minimal access to other body cavity
Z94.2 Right sided operation

Coding standards and guidance

PCSC1: Local anaesthetic for ophthalmology procedures (C90)
Codes in category **C90 Local anaesthetic for ophthalmology procedures** must only be assigned in a secondary position.
These codes are available for Trusts that wish to collect this data for local purposes. With the exception of radiotherapy performed under general anaesthetic, there is **no** mandatory requirement to code anaesthetics. ***See also:*** - ***PCSX20: Radiotherapy (X65, X67–X69)*** - ***PCSY10: Anaesthetic (Y80-Y84).***

CHAPTER D EAR
(D01–D28)

Coding standards and guidance

PCSD2: Replacement of the ossicular chain (D16.8)
When coding a graft replacement of the ossicular chain using a combination of bone plate, fibrin glue and cartilage, code **D16.8 Other specified reconstruction of ossicular chain** must be assigned.

CHAPTER E RESPIRATORY TRACT
(E01–E98)

Coding standards and guidance

Pituitary excision with skull based reconstruction

See PCSB1: Pituitary excision with skull based reconstruction.

PCSE1: Laryngopharyngectomy (E19 and E29)

When coding laryngopharyngectomy the following codes and sequencing must be used:

E19.- **Pharyngectomy**
E29.- **Excision of larynx**

The fourth character codes assigned will be dependent upon whether the excisions are total, partial or unspecified.

Examples:

Laryngopharyngectomy

E19.2 **Partial pharyngectomy**
Includes: Pharyngectomy NEC
E29.6 **Laryngectomy NEC**

Partial vertical laryngectomy and total pharyngectomy

E19.1 **Total pharyngectomy**
E29.3 **Partial vertical laryngectomy**

PCSE2: Diagnostic fibreoptic endoscopic examination of lower respiratory tract (E49)

When bronchoscopy is performed with washings, brushings or biopsy the following codes must be used:

Bronchoscopy with washings:

E49.2 Diagnostic fibreoptic endoscopic examination of lower respiratory tract and lavage of lesion of lower respiratory tract

Bronchoscopy with brushings:

E49.3 Diagnostic fibreoptic endoscopic examination of lower respiratory tract and brush cytology of lesion of lower respiratory tract

Bronchoscopy with brushings and washings:

E49.4 Diagnostic fibreoptic endoscopic examination of lower respiratory tract with lavage and brush cytology of lesion of lower respiratory tract

Bronchoscopy with biopsy, brushings and washings:

E49.5 Diagnostic fibreoptic endoscopic examination of lower respiratory tract with biopsy, lavage and brush cytology of lesion of lower respiratory tract

Bronchoscopy with biopsy and brushings:

E49.1 Diagnostic fibreoptic endoscopic examination of lower respiratory tract and biopsy of lesion of lower respiratory tract
Y21.1 Brush cytology of organ NOC

Bronchoscopy with biopsy and washings:

E49.1 Diagnostic fibreoptic endoscopic examination of lower respiratory tract and biopsy of lesion of lower respiratory tract
Y21.8 Other specified cytology of organ NOC

PCSE3: Endobronchial ultrasound-guided transbronchial needle aspiration of mediastinum (E63.4)

Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) of mediastinum must be coded using the following codes and sequencing:

E63.4 Endoscopic ultrasound examination of mediastinum and biopsy of lesion of mediastinum
Y20.4 Fine needle aspiration NOC

A code(s) from Chapter T must be assigned in addition where mediastinal lymph nodes are biopsied or sampled during an EBUS-TBNA.

Operations on lymph nodes are classified within Chapter T; biopsy or sampling of mediastinal lymph nodes is not included at **E63 Diagnostic endoscopic examination of mediastinum.**

Examples:

Endobronchial ultrasound examination of mediastinum with trans-bronchial fine needle aspiration (FNA) of mediastinum mass and mediastinal lymph node FNA

E63.4 Endoscopic ultrasound examination of mediastinum and biopsy of lesion of mediastinum
Y20.4 Fine needle aspiration NOC
T87.4 Excision or biopsy of mediastinal lymph node
Y20.4 Fine needle aspiration NOC

Endobronchial ultrasound examination of mediastinum with mediastinal lymph node fine needle aspiration only

E63.2 Endobronchial ultrasound examination of mediastinum
T87.4 Excision or biopsy of mediastinal lymph node
Y20.4 Fine needle aspiration NOC

PCSE4: Non operations on lower respiratory tract (E85–E98) and ventilation support (E85)

Codes in categories **E85–E98** must only be used for outpatient coding, or if the patient is admitted solely for the purpose of a procedure/intervention.

The exception to this standard is category **E85 Ventilation support**. Codes within this category must always be assigned when ventilation support is performed in either an inpatient or outpatient setting.

PCSE5: Invasive ventilation with tracheostomy (E85.1)

When a tracheostomy is performed for invasive ventilation the following codes and sequencing must be applied:

E85.1 Invasive ventilation
O48.1 Prone positioning of patient (if applicable)
E42.3 Temporary tracheostomy

PCSE6: Nasendoscopy

Nasendoscopy is a broad term which is used to describe endoscopic examinations of the nose, pharynx and/or larynx. Where 'nasendoscopy' is documented, the following code(s) must be assigned depending on the site(s) examined:

Diagnostic endoscopic examination limited to the nose:

E65.- Diagnostic endoscopic examination of nasal cavity

Diagnostic endoscopic examination of nose and nasopharynx:

E25.3 Diagnostic endoscopic examination of nasopharynx NEC
(or **E25.1 Diagnostic endoscopic examination of nasopharynx and biopsy of lesion of nasopharynx** if a biopsy is taken)

Diagnostic endoscopic examination of nose, pharynx and larynx:

E25.- Diagnostic endoscopic examination of pharynx
E36.- Diagnostic endoscopic examination of larynx

The category **E65** must only be used to classify a nasal endoscopy limited to the nasal cavity (i.e. the nasopharynx is not examined).*

Nasendoscopy may also be referred to as fibreoptic endoscopic evaluation of swallowing (FEES) which is used for direct visualisation of the pharynx and larynx during swallowing.

It is not necessary to assign **Y76.6 Endonasal endoscopic approach to other body cavity** in addition to identify the method of approach was via the nose; the endoscopic approach is already captured within the endoscopic categories **E25**, **E36** and **E65**, ***see PCSY6: Approach to organ (Y46–Y52 and Y74-Y77).***

Examples:

Nasal endoscopy performed to check for foreign body in left nostril. Responsible consultant confirms the nasopharynx was not examined.

E65.9 Unspecified diagnostic endoscopic examination of nasal cavity

Flexible nasendoscopy (FNE) performed. Responsible consultant confirmed endoscopic examination of nose, nasopharynx, oropharynx, hypopharynx and larynx.

E25.9 Unspecified diagnostic endoscopic examination of pharynx
E36.9 Unspecified diagnostic endoscopic examination of larynx

Fibreoptic endoscopic examination of swallowing (FEES). Pharyngeal and laryngeal structures examined; post swallow revealed no penetration into the airway or aspiration.

E25.9 Unspecified diagnostic endoscopic examination of pharynx
E36.9 Unspecified diagnostic endoscopic examination of larynx

CHAPTER G UPPER DIGESTIVE TRACT (G01–G82)

Chapter standards and guidance

PChSG1: Failed intubation at upper gastrointestinal tract endoscopy
When a patient is admitted for a gastrointestinal tract endoscopy and the patient is unable to tolerate the scope and statements such as ‘failed intubation’ is documented in the medical record; the procedure must not be coded unless the point of abandonment is beyond the mouth. ***See PGCS3: Incomplete, unfinished, abandoned and failed procedures.***
If the point of abandonment of the procedure is no further than the mouth, or if it has not been identified, this cannot be coded using OPCS-4. However, the coder must clarify the point of abandonment with the responsible consultant if this information has not been documented in the medical record. The appropriate ICD-10 code(s) for the condition(s) which prompted the endoscopy to be performed (e.g. gastric ulcer, epigastric pain, gastrointestinal bleed) are assigned.

Examples:

Patient with dysphagia admitted for upper GI endoscopy. Intubation failed and the scope was removed (from the pharynx) by the patient and the procedure could not be completed

E25.9 Unspecified diagnostic endoscopic examination of pharynx

The ICD-10 code for dysphagia would also be assigned.

Patient with epigastric pain admitted for gastroscopy. The patient could not tolerate the scope in his mouth and the procedure could not be performed.

No OPCS-4 codes are assigned

The ICD-10 code for epigastric pain would be assigned.

Conversion procedures

See PGCS16: Conversion procedures.

Endoscopic ultrasound staging examination

See PCSY5: Endoscopic ultrasound staging examination of organ NOC (Y41.2) for the standards for coding an endoscopic ultrasound examination (EUS) performed as a staging examination.

Coding standards and guidance

PCSG1: Non-endoscopic oesophageal balloon dilation under image control (G21.4)

Oesophageal balloon dilation under image control, not using an endoscope must be coded using the following codes and sequencing:

G21.4 Intubation of oesophagus NEC
Y40.3 Balloon dilation of organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

Code **G30.5 Maintenance of gastric band** also includes:

- Maintenance of gastric port
- Attention to gastric band connecting tube
- Resiting of gastric band access port
- Replacement of gastric band access port

See also PGCS17: Maintenance and attention to procedures.

PCSG2: Non endoscopic removal of percutaneous endoscopic gastrostomy (G34.5 and Y03.7)

Non-endoscopic removal of percutaneous endoscopic gastrostomy (PEG) must be coded to:

G34.5 Attention to gastrostomy tube
Y03.7 Removal of prosthesis from organ NOC

PCSG6: Endoscopic insertion of nasogastric or nasojejunal feeding tube (G47.5 and G67.5)

Endoscopic insertion of a nasogastric (NG) or nasojejunal (NJ) feeding tube must be coded using:

G47.5 Insertion of nasogastric tube or **G67.5 Insertion of nasojejunal tube**
Y76.3 Endoscopic approach to other body cavity

PCSG4: Removal or renewal of gastric balloon (G48.6)

The removal of a gastric balloon must be coded using the following codes:

G48.6 Attention to gastric balloon
Y03.7 Removal of prosthesis from organ NOC

The renewal of a gastric balloon must be coded using the following codes:

G48.6 Attention to gastric balloon
Y03.2 Renewal of prosthesis in organ NOC

CHAPTER H LOWER DIGESTIVE TRACT (H01–H73)

Chapter standards and guidance

Emergency procedures

Separate categories exist within this chapter to classify emergency procedures. ***See PGCS15: Emergency procedures.***

Insertion and removal of mesh (Y26 and Y28)

See PCSY13: Insertion and removal of mesh (Y26 and Y28)

A guidance table for the coding of procedures performed for female Pelvic Organ Prolapse (POP) and Stress Urinary Incontinence (SUI) is provided in ***Appendix 1: Procedures performed for pelvic organ prolapse and stress urinary incontinence*** The table is intended to assist coders in the assignment of the correct codes for the procedures which are not easily reached using the OPCS-4 Alphabetical Index.

Coding standards and guidance

PCSH1: Closure or reversal of Hartmann's procedure (H15.4)

The following codes must be assigned for reversal or closure of Hartmann's procedure:

H15.4 Closure of colostomy
Y16.2 Anastomosis of organ NOC
Z29.1 Rectum

PCSH2: Colonoscopy with ileal intubation (H22.1)

A colonoscopy with ileal intubation and biopsy of the terminal ileum is classified using the following codes and sequencing:

H22.1 Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon
Z27.6 Ileum.

A code from category **G80.- Diagnostic endoscopic examination of ileum** must only be assigned if it is specifically documented in the medical record that the patient had a diagnostic ileoscopy or a diagnostic endoscopic examination of the ileum.

PCSH3: Banding of haemorrhoids during endoscopic procedures (H52.4)

When banding of haemorrhoids is carried out in conjunction with an endoscopic procedure, both **H52.4 Rubber band ligation of haemorrhoid** and the OPCS-4 endoscopic procedure code must be assigned.

Example:

Sigmoidoscopy and biopsy of sigmoid colon with banding of haemorrhoids

H52.4 Rubber band ligation of haemorrhoid
H25.1 Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel using fibreoptic sigmoidoscope
Z28.6 Sigmoid colon

PCSH4: Antegrade colonic enema (H62.5)

The following codes must be assigned for antegrade colonic enema:

H62.5 Irrigation of bowel NEC
Y51.5 Approach to organ through appendicostomy

Haemorrhoidal artery ligation (L70.3)

For the standard for coding Haemorrhoidal artery ligation (HALO). ***See PCSL2: Haemorrhoidal artery ligation (L70.3).***

CHAPTER J OTHER ABDOMINAL ORGANS – PRINCIPALLY DIGESTIVE
(J01–J77)

Chapter standards and guidance

PChSJ1: Operations on blood vessel of liver

Where an operation on a blood vessel of the liver does not have a specific code in Chapter J Other abdominal organs – principally digestive, but a specific operation code exists in Chapter L Arteries and Veins, the Chapter L code must be assigned.

See also:
- ***PChSY1: Use of codes in Chapter Y***
- ***PCSZ1: Site codes***

Example:

Percutaneous transluminal hepatic vein occlusion using image control

L99.5 Percutaneous transluminal occlusion of vein NEC
Y53.9 Unspecified approach to organ under image control
Z39.6 Hepatic vein

Drug-eluting balloons (Y37.2)

See PCSY15: Drug-eluting balloons (Y37.2) for the use of code **Y37.2 Introduction of substance into organ using drug-eluting balloon NOC.**

Endoscopic ultrasound staging examination

See PCSY5: Endoscopic ultrasound staging examination of organ NOC (Y41.2) for the standards for coding an endoscopic ultrasound examination (EUS) performed as a staging examination.

See Chapter Y for guidance on the use of codes in category Y79 Approach to organ through artery to specify the artery used for transluminal approaches.

Coding standards and guidance

Endoscopic retrograde cholangiopancreatography standard exception

If a diagnostic endoscopic procedure proceeds to a therapeutic endoscopic procedure on the same site during the same theatre visit, only the therapeutic procedure is coded (***See PGCS10 Coding endoscopic procedures***). An exception to this standard is endoscopic retrograde cholangiopancreatography (ERCP) performed concurrently with a therapeutic endoscopic procedure as indicated by the notes at the appropriate codes within the Tabular list.

PCSJ4: Transarterial chemoembolisation (TACE) of the liver

Transarterial chemoembolisation (TACE) of the liver must be coded using the following codes and sequencing:

J10.1 **Percutaneous transluminal embolisation of hepatic artery**
Y09.2 **Injection of other destructive substance into organ NOC**
Y53.- **Approach to organ under image control** or **Y68.- Other approach to organ under image control**
X72.- **Delivery of chemotherapy for neoplasm**

See also:

- ***PRule 11: National Tariff Chemotherapy Regimens List***
- ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)***
- ***PCSX28: Route of administration of chemotherapy for neoplasm***

PCSJ1: Selective internal radiotherapy (SIRT) of liver using microspheres (J12.3)

Selective internal radiotherapy (SIRT) of liver using microspheres under image control must be coded using the following codes and sequencing:

J12.3 **Selective internal radiotherapy with microspheres to lesion of liver**
X65.3 **Delivery of a fraction of interstitial radiotherapy**
Y36.4 **Introduction of non-removable radioactive substance into organ for brachytherapy NOC**
Y89.- **Brachytherapy** (where necessary)
Y53.- **Approach to organ under image control** or **Y68.- Other approach to organ under image control**

See also PCSX20: Radiotherapy (X65, X67–X69).

PCSJ2: Failed or abandoned endoscopic retrograde cholangiopancreatography (J43.9)

A failed or abandoned ERCP, (i.e. an ERCP with incomplete insertion of the endoscope, or complete insertion of the endoscope but the ampulla cannot be cannulated) must be coded as **J43.9 Unspecified diagnostic endoscopic retrograde examination of bile duct and pancreatic duct**. This is the exception to the coding standard for failed procedures (***See PGCS3: Incomplete, unfinished, abandoned and failed procedures***).

PCSJ3: Cholecystectomy with endoscopic retrograde cholangiopancreatography

When endoscopic retrograde cholangiopancreatography (ERCP) is performed at the same time as cholecystectomy, the ERCP must be coded in a secondary position.

CHAPTER K HEART
(K01–K78)

Chapter standards and guidance

PChSK1: Percutaneous transluminal operations that do not have a specific code

When a procedure is performed using a percutaneous transluminal approach, and no specific 4th character procedure code exists that classifies the procedure at a percutaneous transluminal category, but there is a code which classifies the open procedure, the following codes and sequencing must be used:

Open procedure code
Y79.- **Approach to organ through artery** or **Y76.8 Other specified minimal access to other body cavity** (if the approach is through a vein)*****
Y53.- **Approach to organ under image control** or **Y68.- Other approach to organ under image control**
Z site code(s) (if applicable)

*When more than one percutaneous transluminal procedure has been performed, a code from category **Y79** or code **Y76.8** must be assigned after each open procedure code.

See also:

- ***PCSK1: Transcatheter aortic valve implantation (K26)***
- ***PCSY6: Approach to organ (Y45–Y52 and Y74-Y77)***
- ***PCSY7: Approach to organ under image control (Y53, Y68 and Y78)***

Examples:

Transluminal percutaneous mitral valve annuloplasty, performed through femoral vein, under fluoroscopic image control

K34.1 **Annuloplasty of mitral valve**
Y76.8 **Other specified minimal access to other body cavity**
Y53.4 **Approach to organ under fluoroscopic control**

Transluminal percutaneous balloon dilation of right ventricular outflow tract obstruction, performed through left femoral artery and right and left femoral vein, under fluoroscopic image control

K24.1 Relief of right ventricular outflow tract obstruction
Y76.8 Other specified minimal access to other body cavity
Y79.3 Transluminal approach to organ through femoral artery
Y40.3 Balloon dilation of organ NOC
Y53.4 Approach to organ under fluoroscopic control

See Chapter Y for guidance on the use of codes in category Y79 Approach to organ through artery to specify the artery used for transluminal approaches.

PChSK2: Coding laterality on procedures in Chapter K

Z94.- Laterality of operation must not be assigned in addition to procedures in Chapter K.

See also PCSZ2: Laterality of operation (Z94)

Drug-eluting balloons (Y37.2)

See PCSY15: Drug-eluting balloons (Y37.2) for the use of code **Y37.2 Introduction of substance into organ using drug-eluting balloon NOC.**

Approach to organ under image control (Y53, Y68 and Y78)

Many procedures within this chapter are performed using arteriotomy approach and/or image control, ***see PCSY7: Approach to organ under image control (Y53, Y68 and Y78)*** for the standards for the use of codes in categories **Y53, Y68** and **Y78**.

Cardiopulmonary bypass and modified ultrafiltration adjunct to cardiopulmonary bypass (Y73.1 and Y73.4)

Procedures in this chapter may be performed using cardiopulmonary bypass. For the standards for coding **Y73.1 Cardiopulmonary bypass** and **Y73.4 Modified ultrafiltration adjunct to cardiopulmonary bypass**, ***see PCSY8: Cardiopulmonary bypass and Modified ultrafiltration adjunct to cardiopulmonary bypass (Y73.1 and Y73.4)***.

Coding standards and guidance

PCSK1: Transcatheter aortic valve implantation (K26)

For transcatheter aortic valve implantation (TAVI) using a surgical approach through left ventricle (transapical or transventricular approach) the following codes must be assigned:

K26.- **Plastic repair of aortic valve**
Y49.4 **Transapical approach to heart**
Y53.- **Approach to organ under image control** or **Y68.- Other approach to organ under image control**

For TAVI using a transluminal approach through an artery (i.e. femoral, subclavian, axillary or aorta) the following codes must be assigned:

K26.- **Plastic repair of aortic valve**
Y79.- **Approach to organ through artery**
Y53.- **Approach to organ under image control** or **Y68.- Other approach to organ under image control**

PCSK2: Insertion of a combination of coronary artery stents

When a combination of drug-eluting and metal or plastic stents have been inserted during a coronary artery procedure the following codes and sequencing must be used:

- body system chapter code describing the insertion of the drug-eluting stent
- a code from category **Y14.- Placement of stent in organ NOC** to classify the insertion of the other types of coronary stent(s)
- **Y37.2 Introduction of substance into organ using drug-eluting balloon NOC** (where a drug eluting balloon (DEB) has been used)
- a code from category **Y53.- Approach to organ under image control** or **Y68.- Other approach to organ under image control** to classify the method of image control used.

See also:

- ***PCSY15: Drug-eluting balloons (Y37.2)***

Example:

Percutaneous coronary balloon angioplasty and insertion of two drug-eluting stents and one expanding metal stent into coronary artery using image control

K75.1 Percutaneous transluminal balloon angioplasty and insertion of 1–2 drug-eluting stents into coronary artery
Y14.2 Insertion of expanding metal stent into organ NOC
Y53.9 Unspecified approach to organ under image control

PCSK3: Coronary arteriography with fractional flow reserve measurement or pressure wire studies and coronary angioplasty using fractional flow reserve

When measurement of Fractional Flow Reserve (FFR), or pressure wire studies is performed at the same time as coronary arteriography, the following codes and sequencing must be used:

K63.4 - K63.6 Coronary arteriography
K51.8 Other specified diagnostic transluminal operations on coronary artery
Y44.2 Monitoring of pressure in organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

When coronary angioplasty and/or insertion of stent(s) into the coronary artery/arteries are performed using FFR, or pressure wire studies the following codes and sequencing must be used:

Code classifying angioplasty and/or insertion of stent
Y14.- Placement of stent in organ NOC (when a combination of stents have been inserted)
Y37.2 Introduction of substance into organ using drug-eluting balloon NOC (where a drug-eluting balloon has been used)
Y44.2 Monitoring of pressure in organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

See also:

- ***PCSY15: Drug-eluting balloons (Y37.2)***

Examples:

Coronary arteriography using one catheter and fractional flow reserve (pressure wire studies) under percutaneous image control

K63.5 Coronary arteriography using single catheter
K51.8 Other specified diagnostic transluminal operations on coronary artery
Y44.2 Monitoring of pressure in organ NOC
Y53.9 Unspecified approach to organ under image control

Percutaneous coronary balloon angioplasty with a drug-eluting balloon and insertion of two drug-eluting stents and one expanding metal stent into coronary artery using FFR guidance under fluoroscopic image control

K75.1 Percutaneous transluminal balloon angioplasty and insertion of 1-2 drug eluting stents into coronary artery
Y14.2 Insertion of expanding metal stent into organ NOC
Y37.2 Introduction of substance into organ using drug-eluting balloon NOC
Y44.2 Monitoring of pressure in organ NOC
Y53.4 Approach to organ under fluoroscopic control

PCSK4: Coronary angioplasty and insertion of coronary stents using intravascular ultrasound guidance

When coronary angioplasty and/or insertion of stent(s) into the coronary artery(s) are performed using intravascular ultrasound guidance (IVUS) the following codes and sequencing must be used:

Code classifying angioplasty and/or insertion of stent
Y14.- **Placement of stent in organ NOC** (when a combination of stents have been inserted)
Y37.2 **Introduction of substance into organ using drug-eluting balloon NOC** (where a drug-eluting balloon has been used)
Y53.2 **Approach to organ under ultrasonic control** (to identify IVUS)
Y53.- **Approach to organ under image control** (where the method of image control is not ultrasound)

See also:
- ***PCSY15: Drug-eluting balloons (Y37.2)***

Example:

Percutaneous transluminal balloon angioplasty of multiple coronary arteries using IVUS guidance under fluoroscopic image control

K49.2 Percutaneous transluminal balloon angioplasty of multiple coronary arteries
Y53.2 Approach to organ under ultrasonic control
Y53.4 Approach to organ under fluoroscopic control

PCSK10: Renewal of pacemaker generator/battery (K73.- and K74.-)

The renewal of a single chamber, dual chamber or biventricular pacemaker generator (battery) must be coded using a specific renewal of pacemaker code from categories **K73.- Other cardiac pacemaker system introduced through vein** or **K74.- Cardiac pacemaker system**.

K60.3 Renewal of intravenous cardiac pacemaker system NEC and **K61.3 Renewal of cardiac pacemaker system NEC** would be assigned if the type of pacemaker is not documented in the patient's medical record.

Although the Alphabetical Index indicates that codes **K60.3** and **K61.3** are used for the change of a pacemaker battery, where the specific type of pacemaker is known then a code from categories **K73.-** and **K74.-** must be used as there is a significant resource difference between these renewal procedures.

PCSK9: Coronary lithotripsy (K50.8 and K75.-)

When coronary lithotripsy is performed together with the insertion of coronary stent(s), the following codes must be used:

K75.- Percutaneous transluminal balloon angioplasty and insertion of stent into coronary artery
Y37.2 Introduction of substance into organ using drug-eluting balloon NOC (where a drug-eluting balloon has been used)
Y17.3 Lithotripsy of lesion of organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

See also:

- ***PCSY15: Drug-eluting balloons (Y37.2)***

When coronary lithotripsy is performed without insertion of coronary stent, the following codes must be used:

K50.8 Other specified other therapeutic transluminal operations on coronary artery
Y17.3 Lithotripsy of lesion of organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

PCSK5: Insertion of ventricular assist device (K54 and K56.2)

For the insertion of a ventricular assist device (VAD) using an open approach assign the following codes:

K54.- Open heart assist operations
Y70.5 Temporary operations

For the insertion of a ventricular assist device (VAD) using a percutaneous approach assign the following codes:

K56.2 Transluminal insertion of heart assist system NEC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control** (if image control is used)
Y70.5 Temporary operations

PCSK6: Ablation of the heart with 3D mapping (K58.6)

3D mapping of the heart is an inherent part of ablation of the conducting system of the heart and is rarely performed on its own, therefore code **K58.6 Percutaneous transluminal three dimensional electroanatomic mapping of conducting system of heart** must not be assigned in addition to an ablation code from categories **K57 Other therapeutic transluminal operations on heart** or **K62 Therapeutic transluminal operations on heart**.

PCSK7: Implantation and renewal of cardiac resynchronisation therapy defibrillator (K59.6 and K59.7)

Implantation or renewal of a cardiac resynchronisation therapy defibrillator (CRT-D) device using either **two or three** leads is coded to **K59.6 Implantation of cardioverter**

defibrillator using three electrode leads or K59.7 Renewal of cardioverter defibrillator using three electrode leads.

Evaluation of cardioverter defibrillator (X50.5)

See PCSX15: Evaluation of cardioverter defibrillator (X50.5)

PCSK8: Angiocardiography (ventriculography) of the heart and coronary arteriography (K63)

When an angiocardiography (ventriculography) of the heart (codes **K63.1-K63.3**) is performed with a coronary arteriography (codes **K63.4-K63.6),** during the same radiology/theatre visit, both procedures must be recorded. A code from category **Y53.- Approach to organ under image control or Y68.- Other approach to organ under image control** must also be assigned in a secondary position in order to classify the method of image control used.

A code from category **K65 Catheterisation of heart** must not be assigned in addition to codes in category **K63 Contrast radiology of heart** as catheterisation is implicit within these codes.

Examples:

Coronary arteriography using two catheters performed during the same radiology/theatre visit with a left ventriculography under percutaneous image control

K63.3 Angiocardiography of left side of heart NEC
K63.4 Coronary arteriography using two catheters
Y53.9 Unspecified approach to organ under image control

Cardiac catheterisation with angiocardiography of right and left side of heart using image control

K63.1 Angiocardiography of combination of right and left side of heart
Y53.9 Unspecified approach to organ under image control

CHAPTER L ARTERIES AND VEINS
(L01–L99, O01–O05, O15, O20)

Chapter standards and guidance

See PChSJ1: Operations on blood vessel of liver for guidance on the use of codes in Chapter L for operations on blood vessels of the liver.

Procedures carried out on coronary blood vessels are excluded from this Chapter and are classified in Chapter K Heart instead.

Certain specific blood vessels are excluded from this chapter and are classified in other body system chapters, e.g. ligation of maxillary artery using sublabial approach is coded to **E12.1**.

See Chapter Y for guidance on the use of codes in category Y79 Approach to organ through artery to specify the artery used for transluminal approaches.

Approach to organ under image control (Y53, Y68 and Y78)

Many procedures within this chapter are performed using arteriotomy approach and/or image control, ***see PCSY7: Approach to organ under image control (Y53, Y68 and Y78)*** for the standards for the use of codes in categories **Y53, Y68** and **Y78**.

Emergency procedures

Separate categories exist within this chapter to classify emergency procedures. See ***PGCS15: Emergency procedures.***

Cardiopulmonary bypass (Y73.1)

Procedures in this chapter may be performed using cardiopulmonary bypass, for the standards for coding **Y73.1 Cardiopulmonary bypass *see PCSY8: Cardiopulmonary***

bypass and modified ultrafiltration adjunct to cardiopulmonary bypass (Y73.1 and Y73.4).

PChSL1: Interventions not specifically classifiable within a named artery category

Codes in categories **L65-L72** must not be used when an intervention is classifiable within a named artery category from the range **L01–L63**

Codes within principal category **L71 Therapeutic transluminal operations on other artery** and extended category **L66 Other therapeutic transluminal operations on artery** must be used to code interventions not classifiable at fourth-character level within named artery categories. A site code from Chapter Z must also be assigned.

For 'other specified' and 'unspecified' procedures on named arteries that cannot be classified at specific fourth-characters within categories **L66** and **L71**, the **.8** and **.9** subcategories at named artery categories, e.g. **L63.8**, **L63.9** etc. must be used instead.

Example:

Percutaneous transluminal atherectomy of common femoral artery under image control

L71.7 Percutaneous transluminal atherectomy
Note: Use a subsidiary code to identify method of image control (Y53)
Y53.9 Unspecified approach to organ under image control
Z38.3 Common femoral artery

Although this procedure is on the femoral artery which appears at a number of categories as a named artery (**L56–L63**), a code does not exist which classifies percutaneous atherectomy of the femoral artery within this range, therefore as a code is available at category **L71**, it must be classified here together with a site code from Chapter Z to identify the specific artery.

PChSL2: Assigning codes for specifically classifiable arteries

Only when an artery or its branches is specified in the category/code description or at the category inclusions can these codes be assigned. A site code must be assigned in addition when the artery is listed as an inclusion term.

Where the artery is not specifically referred to within the code description or inclusion, even if the origin is known, do **not** assign a code from these categories. A code from categories

L65–L72 must be used instead with the addition of a site code from Chapter Z where available.

Due to the vast number of arteries in the human body, it is not possible to allocate categories for specific operations on every named artery, down to the smallest branch. Specific categories are available in Chapter L for the major branches of the aorta and specified tributaries which are included within each as inclusion terms where appropriate.

This allows the classification of a major part of arterial surgery into a relatively small number of discrete anatomical groups. This specification does not extend beyond the actual named vessels.

Examples:

Ligation of axillary artery

L38.2 Ligation of subclavian artery
Includes: Axillary artery
Brachial artery
Vertebral artery
Z36.3 Axillary artery

Ligation of splenic artery

L70.3 Ligation of artery NEC
Z37.7 Splenic artery

PChSL3: Insertion of stents and stent grafts

Codes within Chapter L which classify the insertion of stents or stent grafts must be supplemented by a code from categories **L76**, **L89** or **O20**, to indicate the type and number of stents/stent grafts inserted, as indicated by the ***Notes*** at category or code level.

When a stent has been inserted and the number and type of stent(s) is unknown, the default code is **L76.9 Unspecified endovascular placement of stent.**

When a stent graft has been inserted and the number and type of stent graft(s) is unknown, the default code is **O20.9 Unspecified endovascular placement of stent graft.**

When extensions to an existing stent graft are placed during a separate procedure to the original stent graft insertion, these must be classified using **L27.8 Other specified transluminal insertion of stent graft for aneurysmal segment of aorta** and **Y15.- Attention to stent in organ NOC**.

When angioplasty/venoplasty and insertion of stent or stent graft are performed at the same time and individual codes are available for the angioplasty/venoplasty and for the stent/stent graft insertion, only the code for the stent/stent graft insertion is required, because the angioplasty/venoplasty is implicit within the stent/stent graft insertion code.

When a drug-eluting balloon is used **Y37.2 Introduction of substance into organ using drug-eluting balloon NOC** must be assigned in addition to the codes for the stenting procedure.

See also:

- ***PCSY15: Drug-eluting balloons (Y37.2)***
- ***PChSY1: Use of codes in Chapter Y***

Where information is available about the type of stent/stent graft placed, codes in categories **L76 Endovascular placement of stent**, **L89 Other endovascular placement of stent** and **O20 Endovascular placement of stent graft** must be assigned in a subsidiary position to the code describing the insertion of the stent/stent graft.

A stent graft can be made up of multiple components from a single stent graft kit which can be modified and connected together to replace the vessel(s) affected by an aneurysm. Stent graft extensions are components of a single stent graft kit and as such are not separate stent grafts.

If the brand name of the stent/stent graft kit is documented in the medical record in preference to the type of stent/stent graft used, the clinical coder must liaise with the responsible consultant to ascertain the type(s) of stent/stent graft.

A subsidiary code note exists at certain codes in **Chapter L Arteries and veins**, but codes in categories **L76**, **L89** and **O20** can also be assigned to stent codes where this note is not present.

Examples:

Percutaneous transluminal balloon angioplasty of pulmonary artery and insertion of one metallic stent under ultrasonic control

L13.6 Percutaneous transluminal insertion of stent into pulmonary artery
Note: Use a supplementary code for placement of stent (L76, L89, O20)
Note: Use a subsidiary code to identify method of image control (Y53)
L76.1 Endovascular placement of one metallic stent
Y53.2 Approach to organ under ultrasonic control

Insertion of two endovascular stent grafts into thoracic aortic aneurysm using femoral arteriotomy approach under ultrasonic guidance

L27.3 Endovascular insertion of stent graft for thoracic aortic aneurysm
Note: Use a subsidiary code to identify arteriotomy approach to organ under image control (Y78)
Note: Use a supplementary code for placement of stent (O20)
O20.4 Endovascular placement of two stent grafts
Y78.3 Arteriotomy approach to organ using image guidance with ultrasound

PChSL4: Removal of bypass grafts

The removal of bypass grafts must be coded to the original operation bypass category with the fourth-character **.8** plus code **Y26.4 Removal of other repair material from organ NOC** unless there is a specific fourth-character code that classifies removal of the bypass graft.

Example:

Removal of femoral bypass graft

L59.8 Other specified other bypass of femoral artery
Y26.4 Removal of other repair material from organ NOC

Drug-eluting balloons (Y37.2)

See PCSY15: Drug-eluting balloons (Y37.2) for the use of code **Y37.2 Introduction of substance into organ using drug-eluting balloon NOC.**

Coding standards and guidance

Category **L04** classifies procedures on ***both*** pulmonary arteries, so it is not necessary to add code **Z94.1** to indicate a bilateral operation.

PCSL1: Anastomosis without a site specific code (L16-L28 and L48-L63)

Anastomotic sites that are not specifically indicated at the fourth-character level within categories **L16-L28** and **L48-L63** must be assigned to the **.8** within the relevant category.

Example:

Bypass of segment of aorta by anastomosis of aorta to common femoral artery

L21.8 Other specified other bypass of segment of aorta

PCSL8: Replacement/repair of aorta for aortic aneurysm and aortic dissection (L18-L21, L27-L28)
When multiple segments of the aorta are replaced/repaired and the individual segments are classifiable to different four character codes, each segment replaced/repaired must be coded separately. 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. The open replacement of the aorta for an aortic dissection *without* aneurysm must be classified to categories **L20 Other emergency bypass of segment of aorta** or **L21 Other bypass of segment of aorta**. When a Frozen Elephant Trunk (FET) procedure has been performed, this must be classified using the appropriate open replacement/repair code from categories **L18 – L21** and a supplementary code from **O20 Endovascular placement of stent graft.** ***See also PGCS15: Emergency procedures.***
A Frozen Elephant Trunk (FET) is a single-stage hybrid procedure, combining a conventional open approach with endovascular techniques to treat extensive aortic aneurysms or aortic dissections.

Bare metal stents (without covering material) are not used in endovascular aortic aneurysm repair therefore where only ‘stent’ (bare metal stent) and not ‘stent-graft’ (stent with material covering) is documented in the medical record the coder should check to see if, in fact, a stent graft has been used and assign a code from category **L27 Transluminal insertion of stent graft for aneurysmal segment of aorta**.

PCSL2: Haemorrhoidal artery ligation (L70.3)

Haemorrhoidal artery ligation (HALO) is an ultrasound guided procedure, performed on the arteries supplying blood to the haemorrhoids rather than on the haemorrhoids themselves. The following codes and sequencing must be used to classify this procedure:

L70.3 Ligation of artery NEC
Y52.4 Peranal transrectal approach to organ
Y53.2 Approach to organ under ultrasonic control
Z37.8 Specified lateral branch of abdominal aorta NEC

PCSL3: Embolisation of uterine fibroids (L71.3)

Embolisation of uterine fibroids is performed under image control on the uterine artery which supplies blood to the fibroids. Therefore the following codes must be used to classify this procedure:

L71.3 Percutaneous transluminal embolisation of artery
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**
Z96.6 Uterine artery
Z94.- Laterality of operation

As code **L73.1 Mechanical embolic protection NEC** would only be used to denote a mechanical embolic protection which is *not* covered more precisely by any other code, e.g. **L73.2 Mechanical embolic protection of artery,** it is expected that codes **L73.8** and **L73.9** would not be used. To maintain the integrity of the classification these codes are included.

PCSL4: Fistuloplasty of arteriovenous fistula (L74.3)

Fistuloplasty of an arteriovenous fistula is coded using the following codes and sequencing:

L74.3 Attention to arteriovenous shunt
Y40.- Dilation of organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control** (if image control is used)
Z site code (when the site is stated)

Z94.- Laterality

PCSL5: Varicose vein operations (L84, L85 and L87)

Codes from category **L84 Combined operations on varicose vein of leg** must be used when any **ligation**, **stripping** or **avulsion** of varicose veins of leg, described in categories **L85 Ligation of varicose vein of leg** and **L87 Other operations on varicose vein of leg,** are performed at the same time.

Example:

Stripping and avulsion of right recurrent long saphenous vein

L84.4 Combined operations on recurrent long saphenous vein
Z94.2 Right sided operation

PCSL6: Insertion of vascular closure device (L97.6)

L97.6 Insertion of vascular closure device must only be assigned when a patient returns to theatre for closure of a bleeding or leaking operative puncture wound.

L97.6 Insertion of vascular closure device must not be assigned when a vascular closure device is applied as part of a main procedure to close and seal the arteries at the end of the procedure.

PCSL7: Aneurysm sizes (O01)

The sizes of aneurysms described at category **O01 Transluminal coil embolisation of aneurysm of artery** are as follows:

- Small = 5mm or less
- Medium = 6mm–10mm
- Large = 11mm–20mm
- Giant = greater than 20mm.

CHAPTER M URINARY
(M01–M86)

Chapter standards and guidance

Insertion and removal of mesh (Y26 and Y28)

See PCSY13: Insertion and removal of mesh (Y26 and Y28)

A guidance table for the coding of procedures performed for female Pelvic Organ Prolapse (POP) and Stress Urinary Incontinence (SUI) is provided in ***Appendix 1: Procedures performed for female pelvic organ prolapse and stress urinary incontinence.*** The table is intended to assist coders in the assignment of the correct codes for the procedures which are not easily reached using the OPCS-4 Alphabetical Index.

Coding standards and guidance

PCSM1: Percutaneous drainage of kidney (M13.2)

Code **M13.2 Percutaneous drainage of kidney** includes the insertion of a nephrostomy tube for drainage. The insertion of the nephrostomy tube must not be coded in addition.

Ureteric stents are mainly inserted cystoscopically, however, they can also be inserted using other methods, for example, percutaneously and in a few cases ureteroscopically where it has not been possible to pass a guidewire cystoscopically. Ureteric stent insertions (and change of stents) are therefore classified according to the method used.

PCSM3: Extracorporeal shockwave lithotripsy of calculus of ureter (M31.1)

Cystoscopy and/or the insertion of a stent must not be coded in addition to **M31.1 Extracorporeal shockwave lithotripsy of calculus of ureter**, as these are integral parts of the procedure. A code from **Y53.- Approach to organ under image control** or **Y68.- Other approach to organ under image control** must be assigned in addition.

However, if the stent is left in situ following the lithotripsy in order to facilitate the passage of fragments of the calculus, then the stent insertion would require coding in addition to **M31.1**, with a code from **Y14.- Placement of stent in organ NOC**, as appropriate.

PCSM12: Cystoscopy with cystodiathermy

Cystoscopy with cystodiathermy, classified at **M42.2 Endoscopic cauterisation of lesion of bladder**, must only be coded when performed as a therapeutic procedure and must not be coded when cystodiathermy is performed only as a means of haemostasis at the end of a procedure.

See also:

- ***PGCS10: Coding endoscopic procedures***
- ***PGCS20: Procedures performed for haemostasis***

PCSM5: Fluorescence cystoscopy and cystoscopy using photodynamic substance

Fluorescence cystoscopy and cystoscopy using a photodynamic substance are coded as follows:

Body system chapter code to classify the cystoscopy
Y37.1 Introduction of photodynamic substance into organ NOC

PCSM6: Catheterisation of the bladder (M47)

Urethral catheterisation (**M47.9 Unspecified urethral catheterisation of bladder**) must **not** be coded when;

- catheter insertion is performed routinely as part of, or following, a procedure
- catheter insertion is performed to keep the patient comfortable during admission, for example in an elderly immobile long stay patient.

  Neither must subsequent removal of the catheter be coded in these instances.

If a patient is catheterised for urinary retention (which may have been present on admission or developed during the admission) the insertion of the urethral catheter and its subsequent removal would **not** be considered a routine part of care and both the insertion and removal of the catheter must be coded.

If a urethral catheter is inserted routinely, but following removal the patient is unable to void urine, this indicates that the patient is in urinary retention. The reinsertion of the urethral catheter, and its subsequent removal following reinsertion, would **not** be considered a routine part of care and both the reinsertion and subsequent removal of the catheter must be coded.

When a patient is admitted for removal of an indwelling urinary catheter or trial without catheter (TWOC), and on removal the patient is unable to void resulting in the catheter being reinserted, this **must** be coded using the following codes and sequencing:

M47.3 Removal of urethral catheter from bladder
M47.9 Unspecified urethral catheterisation of bladder

Examples:

Patient admitted for a right total knee replacement using cement. Two days after surgery the patient develops postoperative urinary retention that requires catheterisation. The catheter is removed prior to discharge:

W40.1 Primary total prosthetic replacement of knee using cement
Z94.2 Right sided operation
M47.9 Unspecified urethral catheterisation of bladder
M47.3 Removal of urethral catheter from bladder

Patient with enlarged prostate. Routine admission for TURP (transurethral resection of prostate). Patient catheterised (as is normal practice following the procedure). Catheter removed prior to discharge:

M65.3 Endoscopic resection of prostate NEC

Routine admission for TURP (transurethral resection of prostate). Patient catheterised (as is normal practice following the procedure). Catheter removed prior to discharge, but patient fails to void. Catheter reinserted and patient is discharged with catheter in situ. To return in one week for removal.

M65.3 Endoscopic resection of prostate NEC
M47.9 Unspecified urethral catheterisation of bladder

Admitted for trial without urethral catheter (TWOC). Patient still unable to void and catheter is reinserted.

M47.3 Removal of urethral catheter from bladder
M47.9 Unspecified urethral catheterisation of bladder

PCSM11: Removal of vaginal and transobturator tape (M53 and M57)

When assigning codes for the removal of vaginal or transobturator tape in categories **M53.- Vaginal operations to support outlet of female bladder** and **M57.- Other vaginal operations to support outlet of female bladder** the method(s) of approach must be coded in addition, even when the method is stated in the category or code description.

The approach may be vaginal (**Y50.3**), open abdominal (**Y50.2**), groin incision/dissection (**Y77.2**), laparoscopic (**Y75.-**) or a combination of these approaches, where multiple approach codes are assigned.

See also:

- ***Appendix 1 for guidance for procedures performed for female pelvic organ prolapse and stress urinary incontinence procedures***
- ***PCSY6: Approach to organ (Y45–Y52 and Y74-Y76)***
- ***PCSY13: Insertion and removal of mesh (Y26 and Y28)***

Category **M53** and its extended category **M57** classify vaginal operations to support the outlet of the female bladder, however some of the removal procedures classified within these categories can be performed using approaches other than through the vagina, including combined approaches, therefore codes for the approach are required in addition to ensure this information is fully captured.

Example:

Total removal of retropubic tape using combined abdominal (open) and vaginal approach.

M53.4 Total removal of tension-free vaginal tape
Y50.3 Vaginal approach
Y50.2 Laparotomy approach NEC

PCSM8: Transurethral incision of male bladder neck and prostate (M66.2)

Transurethral male bladder neck and prostate incision (TUIP) is coded using the following codes and sequencing:

M66.2 Endoscopic incision of outlet of male bladder NEC
Z42.2 Prostate

PCSM9: Radioactive seed implantation into prostate (M70.6)

Radioactive seed implantation into prostate is a form of interstitial brachytherapy (radiotherapy) and must be coded as follows:

M70.6 Radioactive seed implantation into prostate
Note: Use an additional code to specify radiotherapy delivery (X65)
X65.3 Delivery of a fraction of interstitial radiotherapy
Note: Use a subsidiary code to identify introduction of radioactive material (Y35, Y36)
Y36.3 Radioactive seed implantation NOC
Y89.- Brachytherapy (when the dose rate is stated as being high dose or pulsed dose)

See also PCSX20: Radiotherapy (X65, X67–X69).

Radioactive seed implantation into prostate (M70.6) involves the implantation of radioactive seeds into the prostate gland which are placed via hollow needles inserted through the skin. The needles are then removed while the seeds remain in place permanently, eventually becoming biologically inert.
Implantation of radioactive substance into prostate (M71.2) involves the insertion of a thin plastic tube(s) into the prostate gland. A radioactive source is then placed into each tube. After treatment is complete the tubes are removed, leaving no radioactive material in the prostate gland.

PCSM10: Non-endoscopic microwave prostatectomy (M70.8)

Non-endoscopic microwave prostatectomy performed blind via the urethra, or transrectally is coded using the following codes and sequencing:

M70.8 Other specified other operations on outlet of male bladder
Y11.6 Microwave destruction of organ NOC.

CHAPTER N MALE GENITAL ORGANS
(N01–N35)

Coding standards and guidance

PCSN1: Injection of papaverine for impotence (N32.4)
Injection of papaverine for impotence is coded using the following code: **N32.4 Injection of therapeutic substance into penis**

CHAPTER P LOWER FEMALE GENITAL TRACT (P01–P32)

Chapter standards and guidance

Pessaries inserted into the vagina for antiseptic, contraceptive or abortifacient purposes are coded to Chapter Q.

Vaginal procedures carried out to support the outlet of the female bladder, for example, stress incontinence, must be classified to Chapter M.

Insertion and removal of mesh (Y26 and Y28)

See PCSY13: Insertion and removal of mesh (Y26 and Y28)

A guidance table for the coding of procedures performed for female Pelvic Organ Prolapse (POP) and Stress Urinary Incontinence (SUI) is provided in ***Appendix 1: Procedures performed for female pelvic organ prolapse and stress urinary incontinence.*** The table is intended to assist coders in the assignment of the correct codes for the procedures which are not easily reached using the OPCS-4 Alphabetical Index.

Coding standards and guidance

PCSP1: Refashioning of episiotomy scar (P13.8 and S60.4)

Refashioning of an episiotomy scar is coded using the following codes and sequencing:

P13.8 Other specified other operations on female perineum
S60.4 Refashioning of scar NEC

PCSP3: Episiotomy to facilitate delivery of terminated fetus and subsequent repair (P14.9, P13.2, P25.5)

Where an episiotomy (**P14.9**) is carried out to facilitate delivery of a terminated fetus, this must be sequenced in a secondary position to the delivery code (**Q58 Delivery of terminated fetus**).

The subsequent repair of an episiotomy is included within code **P14.9 Unspecified incision of introitus of vagina** and therefore must not be coded in addition.

The exception is where the episiotomy has extended to a perineal or vaginal tear. In these cases, **P13.2 Female perineorrhaphy** or **P25.5 Suture of vagina** must be assigned in addition, to classify the repair of the tear.

See also:

- ***PCSR5: Episiotomy to facilitate delivery and subsequent repair (R27.1, R32)***
- ***Chapter Q for guidance on Delivery of terminated fetus (Q58)***

PCSP4: Repair/reconstruction of hymen and Hymenoplasty

Codes within OPCS-4 must not be used to classify repair/reconstruction of the hymen (hymenoplasty).

The Department of Health and Social Care (DHSC) and Royal College of Obstetricians and Gynaecologists (RCOG) have advised that there are no justified medical or clinical reasons why a hymenoplasty should take place and under no circumstance should it be performed on the NHS. Hymenoplasty is a procedure that reconstructs the hymen. The demand for the procedure is cultural and based on harmful misconceptions that surround female virginity.

As a result, and following a request from the DHSC, **P15.3 Repair of hymen** has been retired from OPCS-4.

In category **P15 Other operations on introitus of vagina** there are other codes for procedures that remove, open, stretch or cut the hymen or extra hymenal tissue which open the vaginal introitus for a number of reasons, for example to treat infection and to aid menstruation and fertility. These procedures do not reconstruct or repair the hymen and can continue to be used.

Coding departments should discuss procedures classified at category **P15** with clinicians within their Trust to ensure correct recording and coding.

The DHSC and RCOG have stated that due to the procedure's connotations and links to other forms of abuse, if clinical colleagues are approached about the procedure, they should contact their safeguarding lead immediately.

See Expert panel on hymenoplasty - GOV.UK (www.gov.uk) for more information.

CHAPTER Q UPPER FEMALE GENITAL TRACT (Q01–Q58)

Chapter standards and guidance

Insertion and removal of mesh (Y26 and Y28)

See PCSY13: Insertion and removal of mesh (Y26 and Y28)

A guidance table for the coding of procedures performed for female Pelvic Organ Prolapse (POP) and Stress Urinary Incontinence (SUI) is provided in ***Appendix 1: Procedures performed for female pelvic organ prolapse and stress urinary incontinence.*** The table is intended to assist coders in the assignment of the correct codes for the procedures which are not easily reached using the OPCS-4 Alphabetical Index.

Gestational age (Y95)

Codes in category **Y95 Gestational age** must be assigned with various codes in Chapter Q – ***see PCSY11:*** **Gestational age (Y95)*.***

Coding standards and guidance

PCSQ1: Colposcopy with punch biopsy (Q03.4 and Q55.4)

Colposcopy and punch biopsy of the cervix must be coded using the following codes and sequencing:

Q03.4 Punch biopsy of cervix uteri
Q55.4 Colposcopy of cervix

PCSQ2: Dilation, curettage (D&C), hysteroscopy and intrauterine coil (Q10.3, Q10.8, Q18.8, Q18.9, Q12)

Dilation and curettage (D&C) and hysteroscopy can be coded differently depending on the reason for the procedure(s) being performed. The following codes and sequencing apply:

Diagnostic D&C only:

Q10.8 Other specified curettage of uterus

Therapeutic D&C only:

Q10.3 Dilation of cervix uteri and curettage of uterus NEC

Diagnostic D&C and diagnostic hysteroscopy:

Q18.8 Other specified diagnostic endoscopic examination of uterus

Therapeutic D&C and diagnostic hysteroscopy:

Q10.3 Dilation of cervix uteri and curettage of uterus NEC
Q18.9 Unspecified diagnostic endoscopic examination of uterus

Hysteroscopy only:

Q18.9 Unspecified diagnostic endoscopic examination of uterus

Unspecified D&C:

Q10.3 Dilation of cervix uteri and curettage of uterus NEC

Unspecified D&C and hysteroscopy:

Q18.9 Unspecified diagnostic endoscopic examination of uterus

Where an intrauterine coil procedure (insertion, replacement or removal) is performed during the same theatre visit as a diagnostic or therapeutic hysteroscopy, the hysteroscopy code must be sequenced before the intrauterine coil code.

Dilation and curettage (D&C) and hysteroscopy can be performed for diagnostic or therapeutic purposes: however, there are often occasions where this can be a combination of the two. For example, a uterine curettage can be performed to provide a tissue sample for diagnostic purposes, but it is also hoped the removal of this tissue will have some therapeutic benefits.

A hysteroscopy will always be carried out in a hospital setting by a gynaecologist. In contrast, the insertion, replacement or removal of an intrauterine contraceptive device (coil) is a relatively minor procedure which is often performed outside of a hospital setting, such as at a GP surgery or community contraceptive clinic. An intrauterine coil can have therapeutic benefits for patients with menorrhagia and dysmenorrhoea, and may be

inserted during the same theatre visit as a hysteroscopy that was performed to investigate and/or treat these conditions.

PCSQ3: In vitro fertilisation (Q13.1, Q21.1 and Q38.3)

A code(s) from category **Y96 In vitro fertilisation (IVF)** must be assigned in a subsidiary position to codes **Q13.1 Transfer of embryo to uterus NEC, Q21.1 Transmyometrial transfer of embryo to uterus** and **Q38.3 Endoscopic intrafallopian transfer of gametes** to classify the *type(s)* of fertilisation involved.

Example:

Transfer of embryo to uterus for in vitro fertilisation using donor sperm and donor egg

Q13.1 Transfer of embryo to uterus NEC
Y96.1 In vitro fertilisation with donor sperm
Y96.2 In vitro fertilisation with donor eggs

PCSQ4: Magnetic Resonance Image-guided Focused Ultrasound to lesion of the uterus (Q20.6)

Magnetic resonance image-guided focused ultrasound [MRgFUS] to lesion of the uterus must be coded using the following codes and sequencing:

Q20.6 Focused ultrasound to lesion of uterus
Y53.7 Approach to organ under magnetic resonance imaging control

PCSQ5: Genital swab (Q55.6)

The code **Q55.6 Genital swab** must only be used for outpatient coding, or if the patient is admitted solely for the purpose of this procedure.

The codes in category **Q58 Delivery of terminated fetus** are for use when it is documented in the medical record that the responsible consultant (for example a midwife) has ‘delivered’ a medically terminated fetus (which may be liveborn or showing no signs of life). The delivery of a terminated fetus is generally performed for late termination of pregnancy.

It is strongly recommended that coding managers work closely with the responsible consultants to ensure codes in category **Q58** are assigned when appropriate.

Examples:

Patient admitted at 23 weeks gestation for a medically induced (prostaglandin pessary) termination of pregnancy. The terminated fetus (in cephalic position) was delivered by the midwife

Q58.1 Cephalic delivery of terminated fetus
Y95.1 Over 20 weeks gestational age
Q14.5 Insertion of prostaglandin pessary
Y95.1 Over 20 weeks gestational age

Patient admitted at 9 weeks gestation for a medical (pessary) termination of pregnancy. The fetus was passed without any complication

Q14.6 Insertion of abortifacient pessary NEC
Y95.3 From 9 weeks to < 14 weeks gestational age

CHAPTER R FEMALE GENITAL TRACT ASSOCIATED WITH PREGNANCY, CHILDBIRTH AND PUERPERIUM (R01–R43)

Chapter standards and guidance

Procedures associated with pregnancy with an abortive outcome are excluded from this Chapter and are classified in Chapter Q instead.

Emergency procedures

Separate categories exist within this chapter to classify emergency procedures. ***See PGCS15: Emergency procedures.***

PChSR1: Coding deliveries (R17-R25)

All deliveries (except delivery following a termination of pregnancy (**Q58**)), regardless of the number of weeks gestation, must be coded as follows:

- A code from categories **R17-R25** must be assigned in a primary procedural position
- Code **R24.9 All normal delivery** must only be assigned for a normal delivery, i.e. when no other code in categories **R17–R25** describing the delivery applies
- If one type of delivery method is used and subsequently changed to another type; only the method used to successfully deliver the baby must be recorded.

When coding caesarean sections:

- Assign a code from category **R17 Elective caesarean delivery** for caesarean sections performed when the patient IS NOT in labour**.**
- Assign a code from category **R18 Other caesarean delivery** for caesarean sections performed when the patient IS in labour (and for all emergency caesarean sections)**.**

When coding multiple deliveries (twins, triplets):

- Each *different* type of delivery must be recorded with the *most serious* being sequenced *first*.
- Where all methods of delivery are identical, only one code is required.

See also Chapter Q for guidance on the coding of deliveries following termination of pregnancy (Q58).

The definition of a normal delivery is the process of giving birth without mechanical intervention with a vertex (top of the head) presentation.

Elective caesareans performed when the patient is in labour are likely to have similar risks to the mothers as emergency caesarean deliveries. It is important, therefore, to make the distinction between an elective caesarean performed when the patient is NOT in labour and an elective caesarean performed when the patient IS in labour.

Examples:

Failed ventouse delivery. Patient goes on to have an emergency lower caesarean section with delivery of a live female infant

R18.2 Lower uterine segment caesarean delivery NEC

Patient, 22 weeks pregnant, normal delivery of live born premature baby

R24.9 All normal delivery

Patient admitted at 40 weeks gestation for pre-planned caesarean section - labour not commenced

R17.9 Unspecified elective caesarean delivery

Patient admitted in labour. Caesarean section planned previously

R18.9 Unspecified other caesarean delivery

Patient admitted in labour. Emergency upper uterine segment caesarean section performed due to fetal distress.

R18.1 Upper uterine segment caesarean delivery NEC

Spontaneous twin delivery, one normal, one breech

R20.1 Spontaneous breech delivery
R24.9 All normal delivery

Gestational age (Y95)

Codes in category **Y95 Gestational age** must be assigned with various codes in Chapter R – ***see PCSY11: Gestational age (Y95).***

Coding standards and guidance

PCSR1: Artificial rupture of membranes (R14.1)

Artificial rupture of membranes (ARM) must be coded to OPCS-4 code **R14.1 Forewater rupture of amniotic membranes.**

PCSR2: Intravenous augmentation when in labour (R15)

When a patient has already commenced in labour and intravenous augmentation is used to stimulate uterine contraction, a code from the OPCS-4 category **R15 Other induction of labour** is assigned.

PCSR3: Forceps delivery (R21)

If a type of forceps is named for cephalic deliveries (**R21–R24**), e.g. Neville Barnes, even though that type may be normally used for a mid forceps delivery, the coder must ascertain that this is in fact the case. The type of delivery, i.e. low, mid or high, and *not* the name of forceps used is the qualifying factor.

PCSR4: Face to pubes presentation (R23)

The delivery of a baby with an abnormal cephalic presentation described as ‘face to pubes’ (without using instrumentation) must be coded using a code in category **R23 Cephalic vaginal delivery with abnormal presentation of head at delivery without instrument.**

PCSR5: Episiotomy to facilitate delivery and subsequent repair (R27.1, R32)

Where an episiotomy (**R27.1**) is carried out to facilitate delivery, this must be sequenced in a secondary position to the delivery code.

The subsequent repair of an episiotomy is included within code **R27.1 Episiotomy to facilitate delivery** and therefore it must not be coded in addition.

The exception is where the episiotomy has extended to a perineal tear. In these cases, a code from category **R32 Repair of obstetric laceration** must be assigned in addition, to classify the repair of the perineal tear.

See also PCSP3: Episiotomy to facilitate delivery of terminated fetus and subsequent repair (P14.9, P13.2, P25.5)

PCSR6: Gentle cord traction for removal of retained placenta

Gentle cord traction performed to remove a retained placenta forms part of the management of 'normal' delivery and cannot be classified using OPCS-4 codes.

Gentle cord traction must not be confused with **R29.1 Manual removal of placenta from delivered uterus**, which includes insertion of a hand into the uterus and usually requires anaesthesia.

PCSR7: Obstetric scans (R36-R43)

Codes within categories **R36–R43** must be used for day cases and inpatients when the patient has been admitted solely for the purpose of a procedure/intervention.

When two or more obstetric scans classified within categories **R37.- Non-routine obstetric scan for fetal observations** and **R38.- Other non-routine obstetric scan** are performed during **one** scanning session, the following codes must be assigned

R37.2 Detailed structural scan
Y95.- Gestational age

Procedures classified to categories **R36**-**R43** are always carried out using ultrasound therefore a code from category **Y53 Approach to organ under image control** or **Y68 Other approach to organ under image control** is not required to identify the method of image control.

See also PCSU1: Diagnostic imaging procedures (U01–U21 and U35–U37).

These types of scans are usually performed in a maternity outpatient setting.

PCSR8: Anti-D injection during pregnancy and following delivery (X30.1)
When Anti-D is injected prophylactically, whether it is during pregnancy or following delivery, abortion or miscarriage, it must be recorded each time it is given using code **X30.1 Injection of Rh immune globulin**.
Anti-D may be administered during the third trimester of pregnancy or following miscarriage or abortion. It may also be administered within 72 hours of the birth.

CHAPTER S SKIN
(S01–S70)

Chapter standards and guidance

The ***Note*** at Chapter S states that these codes must not be used as primary codes for skin of the nipple, eyebrow and lip or for skin of the following sites, canthus, eyelid, external ear, external nose, perianal region, scrotum, male perineum, penis, vulva, female perineum and umbilicus. This is because they are:

- Uniquely named and usually associated with another organ, such as the LIP which is associated with the MOUTH, and form specific categories within other chapters of the classification. For example:

  F04 Other reconstruction of lip
  Includes: Skin of lip

- Or form a major part of the (usually superficial) organ concerned, for example the EXTERNAL EAR is part of the ear, and as such is identified as a site inclusion term. For example:

  D02 Extirpation of lesion of external ear
  Includes: Skin of external ear

PChSS1: Enhancing body system codes using codes from Chapter S

When using a code from Chapter S to enhance a code from another body system chapter the code from Chapter S must be assigned:

- When it provides further information about the procedure that is not specified in the primary body system code
- In a secondary position, directly after the body system code it is enhancing.

Codes from Chapter S can be used to enhance various codes from other body system chapters. This is indicated by the note at the relevant categories in the body system chapters and at the beginning of Chapter S. For example:

B35 Operations on nipple and areola
Note: Codes from Chapter S may be used to enhance these codes

Examples:

Laser destruction of skin ***lesion of right external ear***

D02.2 Destruction of lesion of external ear
Note: Codes from Chapter S may be used to enhance these codes
S09.1 Laser destruction of lesion of skin of head or neck
Z94.2 Right sided operation

Marsupialisation of skin lesion of umbilicus

T29.3 Extirpation of lesion of umbilicus
Includes: Skin of umbilicus
Note: Codes from Chapter S may be used to enhance these codes
S06.2 Marsupialisation of lesion of skin NEC

PChSS2: Coding skin flaps and harvests

Skin flaps must be coded as follows:

Local skin flaps:

- When a specific body system skin flap code is available or when the flap is to the skin of the sites listed at the beginning of Chapter S, assign the appropriate code from the relevant **body system chapter**
- Flap code from Chapter S Skin (if doing so adds further information)*
- Chapter Z site code identifying the specific site/organ being reconstructed or repaired (if this has not already been identified within the body system code)
- **Z94.- Laterality of operation** (if applicable)

Other skin flaps:

- When a specific body system skin flap code is available or when the flap is to the skin of the sites listed at the beginning of Chapter S; assign the appropriate code from the relevant **body system chapter**
- Flap code from Chapter S Skin (if doing so adds further information)*
- Chapter Z site code identifying the specific site/organ being reconstructed or repaired (if this has not already been identified within the body system code)
- **Z94.- Laterality of operation** (if applicable)
- Chapter Y code(s) identifying the type of flap harvested and the site of harvest (unless this is identified within the body system code)

- Chapter Z site code identifying the site of the harvest (if this has not already been identified within the Y harvest code)
- **Z94.- Laterality of operation** (if applicable).

* When coding skin flaps, if a specific body system skin flap code is not available or the flap is **not** to one of the skin sites listed in the ***Note*** at the beginning of Chapter S, do not assign a body system chapter code; begin by assigning the flap code from Chapter S.

See also: PChSS1: Enhancing body system codes using codes from Chapter S

Local flaps have their donor areas touching at the borders or very near to the recipient site. There is no national requirement to assign harvest codes with local skin flap procedure codes; harvest codes can be captured if there is a local need to do so.

Examples:

Reconstruction of the mouth using left radial artery forearm flap (responsible consultant confirmed that the flap included skin and fascia)

F39.1 Reconstruction of mouth using flap NEC
S18.3 Distant fasciocutaneous flap to head or neck NEC
Y59.2 Harvest of radial artery flap of skin and fascia
Z94.3 Left sided operation

Local flap of skin of nose from right cheek (responsible consultant confirmed the flap was a random pattern pedicle flap)

E66.1 Flap of skin to external nose
S26.3 Random pattern local subcutaneous pedicle flap of skin to head or neck
Z94.2 Right sided operation

Right breast reconstruction using free transverse rectus abdominis myocutaneous flap:

B39.1 Reconstruction of breast using free transverse rectus abdominis myocutaneous flap
Z94.2 Right sided operation

Excision of lesion of skin of external nose, repaired with a local flap

E09.1 Excision of lesion of external nose
E66.1 Flap of skin to external nose
S27.5 Local flap of skin to head or neck NEC

Coding standards and guidance

PCSS2: Phototherapy to skin (S12)

Phototherapy to skin must be coded using a code from category **S12 Phototherapy to skin**. This includes when performed for newborn jaundice.

Where the **same** type of phototherapy is administered more than once during a consultant episode, assign the relevant code from category **S12.-** once only. Where *different* types of phototherapy classified to **S12.-** are administered during the same consultant episode, assign a code for each different type of phototherapy once only.

The correct code for phototherapy treatment with a biliblanket is **S12.8 Other specified phototherapy to skin.**

PCSS3: Coding skin grafts and harvests

Skin grafts must be coded as follows:

Skin autografts (graft using material harvested from patient)

- When a specific body system skin graft code is available or when the graft is to the skin of the sites listed at the beginning of Chapter S; assign the appropriate code from the relevant **body system chapter**
- Graft code from Chapter S Skin (if doing so adds further information)*****
- Chapter Z site code identifying the specific site/organ being grafted (if this has not already been identified by the body system code)
- **Z94 Laterality of operation** (if applicable)
- Chapter Y code identifying the type of tissue harvested and the site of the harvest
- Chapter Z site code identifying the site of the harvest (if this has not already been identified within the Y harvest code)
- **Z94.- Laterality of operation** (if applicable).

Other types of skin graft (skin grafts using material not harvested from patient, e.g. allograft and xenograft)

- When a specific body system skin graft code is available or when the graft is to the skin of the sites listed at the beginning of Chapter S; assign the appropriate code from the relevant **body system chapter**
- Graft code from Chapter S Skin, (if doing so adds further information)***** and/or a code from category **Y27. - Graft to organ NOC**

- Chapter Z site code identifying the specific site/organ being grafted (if this has not already been identified by the body system code)
- **Z94.- Laterality of operation** (if applicable)

An additional harvest code must not be assigned when coding skin grafts that are not autografts.

*When coding skin grafts, if a specific body system skin graft code is not available or the graft is **not** to one of the skin sites listed in the ***Note*** at the beginning of Chapter S, do not assign a body system chapter code; begin by assigning the graft code from Chapter S.

See also:

- ***PGCS12: Coding grafts and harvests of sites other than skin***
- ***PCSS5: Debridement and washout of skin and wounds***
- ***PCSX12: Donation of skin (X46.2).***

Dermal Substitutes may be used in combination with skin grafts for deep defects, these are coded in addition to the codes for the skin graft using **S53.7 Application of dermal substitute to skin**.

Examples:

Full thickness skin graft to left canthus, graft harvested from skin of right shoulder

C11.5 Graft of skin to canthus
S36.1 Full thickness autograft of skin to head or neck
Z94.3 Left sided operation
Y58.8 Other specified harvest of skin for graft
Z49.6 Skin of shoulder
Z94.2 Right sided operation

Full thickness skin graft to external nose, graft harvested from right post auricular region

E09.7 Graft of skin to external nose
S36.1 Full thickness autograft of skin to head or neck
Y58.1 Harvest of full thickness skin from post auricular region
Z94.2 Right sided operation

Full thickness autograft and dermal substitute to skin of back, graft harvested from right thigh

S36.2 Full thickness autograft of skin NEC
Z49.4 Skin of back

Y58.8 Other specified harvest of skin for graft
Z50.4 Skin of leg NEC
Z94.2 Right sided operation
S53.7 Application of dermal substitute to skin
Z49.4 Skin of back

Allograft of skin to left eyelid

C14.2 Graft of skin to eyelid
S37.1 Allograft of skin to head or neck
Z94.3 Left sided operation

Allograft of skin to back

S37.2 Allograft of skin NEC
Z49.4 Skin of back

PCSS4: Other closure of skin (S40)

Codes within this category must only be assigned to patients admitted to a paediatric ward solely for the purpose of wound closure, regardless of specialty.

PCSS5: Debridement and washout of skin and wounds

Whenever it is stated within the patient's medical record that skin debridement has been performed, then the debridement **must** always be coded.

Where debridement and washout have been performed at the same time, there is no requirement to code the washout, as it is implicit within the debridement.

Where skin graft and skin debridement have been performed, the skin graft must be selected as the primary code.

See also PCSS3: Coding skin grafts and harvests.

Examples:

Primary suture to laceration of scalp with removal of debris and trimming to edges of wound

S41.1 Primary suture of skin of head or neck NEC
Z48.1 Skin of scalp

S56.1 Debridement of skin of head or neck NEC
Z48.1 Skin of scalp

Primary simple repair of flexor digitorum profundus tendon with debridement and washout of open skin wound of the right hand.

T67.6 Primary simple repair of tendon
Z56.4 Flexor digitorum profundus
S57.1 Debridement of skin NEC
Z50.2 Skin of hand
Z94.2 Right sided operation

Debridement of burnt skin of right shoulder and immediate application of split skin graft (SSG). SSG harvested from patient's right leg.

S35.9 Unspecified split autograft of skin
Z49.6 Skin of shoulder
Z94.2 Right sided operation
Y58.8 Other specified harvest of skin for graft
Z50.4 Skin of leg NEC
Z94.2 Right sided operation
S55.1 Debridement of burnt skin NEC
Z49.6 Skin of shoulder
Z94.2 Right sided operation

The following definitions apply to codes within categories **S41 Suture of skin of head or neck** and **S42 Suture of skin of other site:**

Delayed primary suture of skin

This type of suture is where wound closure is undertaken a few days after injury when risk of contamination or infection has passed, or when the wound would be under too much tension if closed immediately after injury.

Secondary suture of skin

The repair of a wound, some of which has been initially sutured, but the rest has been allowed to remain open until partially healed and covered in healthy granulations.

Resuture of skin

This is a further repair of a wound which has previously been sutured.

PCSS6: Larvae therapy of skin (S58) and Leech therapy of skin (S59)

Codes in categories **S58 Larvae therapy of skin** and **S59 Leech therapy of skin** must only be assigned once per hospital provider spell.

Codes **S62.7 Insertion of diagnostic device into subcutaneous tissue** and **S63.1 Removal of diagnostic device from subcutaneous tissue** include the insertion and removal of continuous blood glucose monitoring devices.

CHAPTER T SOFT TISSUE
(T01–T98)

Chapter standards and guidance

Endoscopic ultrasound staging examination

See PCSY5: Endoscopic ultrasound staging examination of organ NOC (Y41.2) for the standards for coding an endoscopic ultrasound examination (EUS) performed as a staging examination.

Coding standards and guidance

PCST1: Release of tennis elbow (T69 or W78)

If during release of tennis elbow only the tendon is released/freed this must be coded to category **T69 Freeing of tendon**. If the joint is released, this must be coded to category **W78 Release of contracture of joint**.

PCST2: Release of trigger finger (T72.3)

Release of trigger finger must be coded using **T72.3 Release of constriction of sheath of tendon**.

The term ‘block dissection’ does not apply to a specific number of lymph nodes. If the clinician states that they performed a block dissection it is correct to assign a code from category **T85 Block dissection of lymph nodes**, irrespective of the number of nodes removed.

PCST3: Sampling, excision, biopsy or drainage of sentinel lymph node (T86-T88, T91.1 and O14.2)

When sampling, excision, biopsy or drainage of sentinel lymph node is performed the following codes must be assigned:

T86-T88
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control** (if applicable)
O14.2 Sentinel lymph node
Z94.- Laterality of operation (if applicable)

T91.1 Biopsy of sentinel lymph node NEC must only be used when the exact site of the sentinel lymph node is unknown.

Example:

Excision of right sided sentinel axillary lymph node using microbubble contrast enhanced ultrasonic control

T87.3 Excision or biopsy of axillary lymph node
Note: Use subsidiary code for sentinel lymph node (O14.2)
Y68.1 Approach to organ under contrast enhanced ultrasonic control
O14.2 Sentinel lymph node
Z94.2 Right sided operation

Scanning of sentinel lymph node (T91.2)

T91.2 Scanning of sentinel lymph node is a nuclear medicine imaging procedure and a code from categories **Y93, Y94, Y97** and **Y98** must not be assigned in addition.
See PCSU3: Nuclear medicine imaging procedures.

CHAPTER U DIAGNOSTIC IMAGING, TESTING AND REHABILITATION
(U01–U54)

Coding standards and guidance

PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37)

Coding diagnostic imaging procedures using body system chapter codes

When a specific code classifying a diagnostic imaging procedure is available in a body system chapter (Chapters A-T and V–W), for example **Q55.5 Transvaginal ultrasound examination of female genital tract, C87.1 Digital imaging of retina** and scanning codes within the range **R36–R43,** the body system chapter code **must** be used in preference to the codes within categories **U01–U21** and **U34–U37**.

The standard to only code diagnostic imaging procedures in an outpatient setting or if the patient has been admitted solely for the purpose of a procedure/intervention only applies to codes in categories **U01–U21** and **U34–U37** and categories **R36-R43**.

Additional codes from categories **Y97 Radiology with contrast** and **Y98 Radiology procedures** must not be assigned with body system chapter imaging codes.

See also PCSR7: Obstetric scans (R36-R43).

Coding diagnostic imaging using codes from Chapter U

Codes in the range **U01–U21** and their extended categories **U34–U37** are only for use in an outpatient setting, or if a patient has been admitted solely for the purpose of a diagnostic imaging procedure/intervention**.** The exceptions to this standard are:

- **Magnetic Resonance Imaging (MRI)**
- **Computed Tomography (CT)**
- **U19.1 Implantation of electrocardiography loop recorder**
- **U19.7 Removal of electrocardiography loop recorder**
- **U20.1 Transthoracic echocardiography (TTE)**
- **U20.2 Transoesophageal echocardiography (TOE)**
- **U20.3 Intravascular echocardiography**
- **U20.4 Epicardial echocardiography**

These exceptions must always be coded on inpatient and outpatient episodes of care.

The '***Notes***' at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast** (if used) are required - ***see PCSU2 Radiological contrast and body areas (Y97-Y98).***

Categories **Y97** (if used) and **Y98** must also be assigned in addition to codes **U36.2 Positron emission tomography with computed tomography NEC** and **U36.3 Single photon emission computed tomography with computed tomography NEC.**

The codes in categories **U01–U21** that classify nuclear medicine imaging procedures do not require the addition of codes from categories **Y97** or **Y98** – ***see PCSU3 Nuclear medicine imaging procedures.***

Diagnostic imaging of one body area using one method of imaging

When **one** body site alone is scanned and this can be indexed to a code range from **U01–U18, U35** or **U37** assign the following codes**:**

- Specific body system code from **U01–U18**, **U35** or **U37**
- **Y97 Radiology with contrast** (if used)
- **Y98.1 Radiology of one body area (or < 20 minutes)**
- Z site code (if doing so adds further information).
- **Z94.- Laterality of operation** (if applicable)

An indexable body system code must only be recorded **once** for each **visit** to the radiology department documented in the patient's medical record.

Diagnostic imaging of one body area using multiple different types of imaging and diagnostic imaging of multiple body areas

When one body area is scanned during a single visit to the radiology department using multiple types of imaging **or** when more than one area is scanned during a single visit to the radiology department using either the *same* or *different* types of imaging assign the following codes and sequencing for each different type of imaging used:

- The specific fourth character at **U21 Diagnostic imaging procedures** or **U36 Other diagnostic imaging procedures**
- **Y97 Radiology with contrast** (if used)
- **Y98 Radiology procedures** (with the fourth-character selection being reliant upon the number of areas scanned or duration of the scan)
- Z site code(s)
- **Z94.- Laterality of operation** (if applicable)

The exception to this is ***PCSU8: Cardiac computed tomography for calcium scoring and cardiac computed tomography angiography (U10.2)*** *and* ***PCSU9: Bone densitometry (U13.1)***

Specified diagnostic imaging procedures not classifiable to body site or system categories

Where a specific type of imaging is not classifiable at fourth-character level within categories **U01–U18**, **U35** or **U37**, but is available within categories **U21 Diagnostic imaging procedure** or **U36 Other diagnostic imaging procedure** assign the following codes and sequencing:

- The specific fourth character at **U21 Diagnostic imaging procedures** or **U36 Other diagnostic imaging procedures** (excluding **U21.8**)
- **Y97 Radiology with contrast** (if used).
- **Y98 Radiology procedures** (with the fourth-character selection being reliant upon the number of areas scanned)
- Z site code(s)
- **Z94.- Laterality of operation** (if applicable)

Where a specific type of imaging cannot be classified at fourth-character level within categories **U01–U18**, **U35** or **U37**, and there is no fourth-character code available in category **U21** or **U36** assign the following codes and sequencing:

- Residual subcategory **.8** from categories **U01–U18**
- **Y97 Radiology with contrast** (if used).
- **Y98 Radiology procedures** (with the specific fourth-character selected being reliant upon the number of areas scanned).

Code **U21.8 Other specified diagnostic imaging procedures** must not be assigned in these circumstances.

Notes instructing the use of **Y97** and **Y98** are currently missing from codes **U36.2 Positron emission tomography with computed tomography NEC** and **U36.3 Single photon emission computed tomography with computed tomography NEC** will be corrected in the next version of OPCS-4.

Examples:

Computed tomography (CT) of head with pre and post contrast

U05.1 Computed tomography of head

Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)

Y97.1 Radiology with pre and post contrast
Y98.1 Radiology of one body area (or < 20 minutes)

Ultrasound elastography of the liver

U36.4 Ultrasound elastography
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y98.1 Radiology of one body area (or < 20 minutes)
Z30.1 Liver NEC

MRI and CT of head post contrast

U21.1 Magnetic resonance imaging NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y97.3 Radiology with post-contrast
Y98.1 Radiology of one body area (or < 20 minutes)
Z92.1 Head NEC
U21.2 Computed tomography NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y97.3 Radiology with post-contrast
Y98.1 Radiology of one body area (or < 20 minutes)
Z92.1 Head NEC

Diagnostic ultrasound of kidneys and bladder lasting 15 minutes (Outpatient setting)

U21.6 Ultrasound scan NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y98.1 Radiology of one body area (or < 20 minutes)
Z41.1 Kidney
Z94.1 Bilateral operation
Z42.1 Bladder NEC

Code **Y98.1** has been selected because the scan lasted less than 20 minutes and it is the time duration which defines which code from category **Y98.-** when coding ultrasound scans.

Diagnostic ultrasound of kidneys lasting 10 minutes with magnetic resonance imaging (MRI) of abdomen (Outpatient setting)

U21.6 Ultrasound scan NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y98.1 Radiology of one body area (or < 20 minutes)
Z41.1 Kidney
Z94.1 Bilateral operation
U21.1 Magnetic resonance imaging NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y98.1 Radiology of one body area (or < 20 minutes)
Z92.6 Abdomen NEC

Post contrast MRI of lumbar and sacral spine

U21.1 Magnetic resonance imaging NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y97.3 Radiology with post-contrast
Y98.2 Radiology of two body areas
Z66.5 Lumbar vertebra
Z66.8 Specified vertebra NEC

Computed tomography (CT) angiography of left deep femoral artery

U35.5 Computed tomography angiography
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y98.1 Radiology of one body area (or < 20 minutes)
Z38.4 Deep femoral artery
Z94.3 Left sided operation

PCSU2: Radiological contrast and body areas (Y97-Y98)

The '***Notes***' at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast**, if used, are required.

Codes from categories **Y97 Radiology with contrast** or **Y98 Radiology procedures** must not be assigned in addition to nuclear medicine codes in categories **U01–U21** – ***see PCSU3: Nuclear medicine imaging procedures.***

Codes from **Y97 Radiology with contrast** must always be assigned *after* the codes for the specific scan and *before* codes from **Y98 Radiology procedures.**

OPCS-4 codes from categories **Y97 Radiology with contrast** and **Y98 Radiology procedures** must not be used with the diagnostic imaging codes from the body system Chapters A–T and V–W.

Y97 Radiology with contrast:

Codes within category **Y97** must only be assigned if it is stated in the patient's medical record that the imaging procedure has been performed using contrast media. Codes in category **Y97** must be used as follows:

- **Y97.1 Radiology with pre and post contrast** is assigned when image(s) are taken before contrast is given and then again after contrast has been introduced.
- **Y97.3 Radiology with post contrast** is assigned when image(s) are taken after contrast is given.
- When only 'radiology with contrast' is stated in the medical record **Y97.3 Radiology with post contrast** must be used as the default.

The following codes from category **Y97** must not be used:

- **Y97.2 Radiology with pre contrast** as this classifies image(s) taken before contrast is given.
- **Y97.8 Other specified radiology with contrast** and **Y97.9 Unspecified radiology with contrast** as the type of contrast would be coded using **Y97.1** or **Y97.3**.

Y98 Radiology procedures:

Codes within **Y98** are used to classify the following:

- number of body areas scanned/examined or the duration of the scan
- mobile and intraoperative scans
- extensive patient repositioning.

Codes **Y98.1**, **Y98.3** and **Y98.5** are used interchangeably to identify the time duration of the scan *or* the number of body areas examined during the scan.

When coding ultrasound and contrast fluoroscopy, it is the time duration and not the number of body areas that defines which code from category **Y98** must be assigned.

In the case of magnetic resonance imaging, computed tomography and plain x-ray, it is the number of body areas scanned that defines which code must be assigned, irrespective of the time duration taken to perform these scans.

The ‘body areas’ referred to in the codes in category **Y98** relate to the following nine anatomical regions of the body. These must be used as a guide during code assignment:

- **Head**
- **Neck (including cervical spine)**
- **Thorax (including thoracic spine)**
- **Abdomen (including lumbar spine)**
- **Pelvic region (including all organs in genitourinary system, sacral spine and groin)**
- **Right leg**
- **Left leg**
- **Right arm**
- **Left arm.**

It is important the default code **Y98.1 Radiology of one body area (or < 20 minutes)** is selected if the area/duration of scan is not specified. It is the responsibility of the clinician to provide this level of detail in the source document.

Where different methods of radiological imaging are carried out, each method must have a code from **Y98 Radiology procedures** assigned.

Y98.6 Mobile and or intraoperative procedures of any/all body areas and **Y98.7 Extensive patient repositioning to obtain required image series** are used as additional codes to any other codes in category **Y98** when this information has been provided in the medical record. It is therefore permissible for more than one code to be assigned from category **Y98 Radiology procedures** on the same episode of care.

It is important to be very precise about radiology procedures, as a common term like ‘x-ray’ can apply to diverse procedures such as: plain film x-ray, contrast media x-ray, fluoroscopic x-ray, mammography x-ray or CT scan x-ray.

Care must be taken when assigning codes for procedures which are performed using a fluoroscopic approach and contrast fluoroscopy scans, as the latter is simply a diagnostic image of a body area.

Examples:

Computed tomography (CT) of head

U05.1 Computed tomography of head
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y98.1 Radiology of one body area (or < 20 minutes)

Magnetic resonance imaging (MRI) of chest with extensive patient repositioning (pre and post contrast)

U07.2 Magnetic resonance imaging of chest
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y97.1 Radiology with pre and post contrast
Y98.1 Radiology of one body area (or < 20 minutes)
Y98.7 Extensive patient repositioning to obtain required image series

Contrast fluoroscopy scan of the oesophagus lasting 35 minutes

U21.5 Contrast fluoroscopy NEC
Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)
Y97.3 Radiology with post contrast
Y98.3 Radiology of three body areas (or 20-40 minutes)
Z27.1 Oesophagus

Transthoracic bubble contrast echocardiogram

U20.1 Transthoracic echocardiography
Y97.3 Radiology with post contrast
Y98.1 Radiology of one body area (or < 20 minutes)

PCSU3: Nuclear medicine imaging procedures (U01–U21 and U34–U37)

Nuclear medicine imaging codes in the range **U01–U21** and their extended categories **U34–U37** are only for use in an outpatient setting, or if a patient has been admitted solely for the purpose of a nuclear medicine imaging procedure**.** The exceptions to this standard are:

- **Positron Emission Tomography (PET)**
- **Single photon emission computed tomography (SPECT)**

- **Positron emission tomography with computed tomography (PET/CT)**
- **Single photon emission computed tomography with computed tomography (SPECT/CT)**

These exceptions must always be coded on inpatient and outpatient episodes of care.

Codes that classify nuclear medicine procedures within categories **U01–U21** and **U34–U37** are identified by the presence of the '***Note***' indicating to use a subsidiary code to identify **Y93 Gallium-67 imaging** or **Y94 Radiopharmaceutical imaging**. These subsidiary codes must be used if radiopharmaceutical imaging substances are used during a nuclear medicine imaging procedure.

U36.2 Positron emission tomography with computed tomography NEC and **U36.3 Single photon emission computed tomography with computed tomography NEC** require the addition of a code from **Y98 Radiology procedures** in order to capture the number of body areas scanned by the CT element of the procedure. **Y98** must be sequenced following **Y93** or **Y94**.

Codes from categories **Y97 Radiology with contrast** or **Y98 Radiology procedures** must not be assigned in addition to nuclear medicine codes in categories **U01-U21**, ***see PCSU1 Diagnostic imaging procedures (U01–U21 and U34–U37) and PCSU2: Radiological contrast and body areas (Y97-Y98).***

See also PCSU4: Myocardial/Cardiac perfusion scan (U10.6 and U11.5).

Nuclear medicine imaging procedures available in the main body system chapters are **B16.4 Parathyroid washout** and **T91.2 Scanning of sentinel lymph node**. Codes from categories **Y93, Y94, Y97** and **Y98** must not be assigned in addition to the nuclear medicine imaging codes contained within the body system chapters.

Example:

Thyroid nuclear scan using octreotide imaging.

U06.5 Scanning of thyroid gland NEC
Note: Use subsidiary codes to identify gallium-67 imaging (Y93), radiopharmaceutical imaging (Y94)
Y94.2 Octreotide imaging

Positron emission tomography with computed tomography (CT) scan of the liver using yttrium 90 microspheres.

U36.2 Positron emission tomography with computed tomography NEC
Note: Use subsidiary codes to identify gallium-67 imaging (Y93), radiopharmaceutical imaging (Y94)
Y94.8 Other specified radiopharmaceutical imaging
Y98.1 Radiology of one body area (or < 20 minutes)
Z30.1 Liver NEC

PCSU8: Cardiac computed tomography for calcium scoring and cardiac computed tomography angiography (U10.2)

When cardiac/coronary computed tomography for calcium scoring and cardiac/coronary computed tomography angiography (CTA) are carried out during the same visit to the radiology scanner, the following codes must be assigned:

U10.2 Cardiac computed tomography angiography
Y97.- Radiology with contrast
Y98.1 Radiology of one body area (or < 20 minutes)

This is an exception to ***PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37)***.

Where scans of other sites are performed during the same visit to the scanner these must also be coded, in accordance with **PCSU1**.

See also PCSU2: Radiological contrast and body areas (Y97-Y98)

PCSU4: Myocardial/Cardiac perfusion scan (U10.6 and U11.5)

If only the first phase (the stress test) of the perfusion scan is carried out, this must be coded to **U11.5 Thallium stress test**.

If both phases are carried out (the stress test and rest tests) code **U10.6 Myocardial perfusion scan** must be assigned instead, irrespective of the agent used. Where a different agent to thallium is used a code from categories **Y93 Gallium-67 imaging** or **Y94 Radiopharmaceutical imaging** must be assigned in addition.

Codes **U10.6** and **U11.5** are only for use in an outpatient setting, or if a patient has been admitted solely for the purpose of the test/scan. ***See also PCSU3: Nuclear medicine imaging procedures*.**

Myocardial/Cardiac perfusion scans are carried out in two phases: a stress test and a rest test. As well as the radiopharmaceutical Thallium, MIBI and Tetrofosmin are also commonly used for stress tests and are commonly referred to as myocardial perfusion agents.

PCSU9: Bone densitometry (U13.1)

Bone density scans or dual-energy X-ray absorptiometry (DEXA) scans must be coded using the following codes and sequencing, regardless of the number of body areas scanned:

U13.1 Bone densitometry
Y98.- Radiology procedures (with the fourth-character selection being reliant upon the number of areas scanned)
Z site code(s)
Z94.- Laterality of operation (if applicable)

U13.1 must only be used in an outpatient setting or if the patient has been admitted solely for the purpose of a procedure/intervention.

Bone densitometry scan or DEXA scan of multiple areas is therefore an exception to the 'Diagnostic imaging of one body area using multiple different types of imaging and diagnostic imaging of multiple body areas' section of **PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37)**.

Bone densitometry scan or DEXA scan would never be performed using contrast.

Example(s):

Whole body DEXA scan (outpatient setting)

U13.1 Bone densitometry
Y98.5 Radiology of > 4 body areas (or > 40 minutes)
Z92.8 Specified region of body NEC

In the absence of a dedicated code from OPCS-4 Chapter Z to classify whole body, it is recommended that code **Z92.8** is assigned.

PCSU10: Wireless Capsule Endoscopy (U17.7)

When coding **U17.7 Wireless capsule endoscopy of digestive tract** one of the following site codes must be assigned in addition to classify the type of wireless capsule endoscopy:

- **Z27.9 Upper digestive tract NEC**
  To classify upper gastrointestinal capsule endoscopy which looks for abnormalities in the oesophagus and stomach.

- **Z27.7 Small intestine**
  To classify a small bowel capsule endoscopy.

- **Z28.7 Colon NEC**
  To classify a colon (large intestine) capsule endoscopy.

- **Z29.9 Bowel NEC**
  To classify a small and large intestine capsule endoscopy.

Example:

Wireless capsule endoscopy of the small and large intestine to monitor Crohn's progression

U17.7 Wireless capsule endoscopy of digestive tract
Z29.9 Bowel NEC

PCSU5: Diagnostic tests (U22-U33, U38 and U40-U41)

Codes in categories **U22-U33, U38** and **U40-U41** classify diagnostic tests and are only for use in an outpatient setting, or for day cases and inpatients if a patient has been admitted solely for the purpose of the diagnostic test.

The exception is code **U22.1 Electroencephalograph telemetry** which must always be coded on inpatient and outpatient hospital episodes.

EEG telemetry (**U22.1**) is a specialised investigation provided by neurophysiology centres. It is used in the diagnosis of epilepsy, for assessing patients for possible surgical treatments for epilepsy and also for the diagnosis of neurological disorders of sleep. The patient is admitted to hospital where EEG and simultaneous video telemetry is recorded continuously for the entire length of stay. This is usually 3-5 days but can be for a period of up to 21 days. ***See also Chapter A for guidance on Electroencephalography NEC (A84.1)***.

PCSU6: Diagnostic blood tests (U32.1, X36.3, X36.8 and X36.9)

Diagnostic blood tests must **only** be coded when the patient is **admitted solely for the purpose of** the diagnostic blood test, using the following OPCS-4 codes:

U32.1 Human Immunodeficiency Virus blood test
X36.3 Venous sampling
X36.8 Other specified blood withdrawal
X36.9 Unspecified blood withdrawal

Codes **U32.1 Human Immunodeficiency Virus blood test** and **X36.3 Venous sampling,** must only be assigned when these tests are explicitly documented in the patient's medical record or when the responsible consultant has confirmed that these tests have been performed.

Code **X36.8 Other specified blood withdrawal** is assigned when another specified type of blood test, which is not a Human Immunodeficiency Virus blood test or Venous sampling, has been performed.

If the type of diagnostic blood test is not specified, then OPCS-4 code **X36.9 Unspecified blood withdrawal** must be assigned.

Sleep disorders involving respiratory functions, such as sleep apnoea, are normally conducted by a specialist Respiratory team using polysomnography or cardiopulmonary sleep studies which are classified at code **U33.1 Polysomnography**. The emphasis of this test will be towards diagnosing sleep disordered breathing. ***See also Chapter A for guidance on Sleep studies (A84.7).***

PCSU7: Rehabilitation (U50-U54)

Rehabilitation codes **U50–U54** must ***only*** be used when a patient is either:

- admitted to a rehabilitation unit solely for the purpose of rehabilitation

  or
- is transferred to a rehabilitation specialty either within the same trust or at a different trust.

They must be assigned on each consultant episode in which the patient is undergoing rehabilitation.

Where a patient receives rehabilitation assessment (**X60**) and rehabilitation delivery (**U50–U54**) within the same admission, only one code is required, with that code being from **U50–U54**, as it is assumed the assessment would have been carried out before the rehabilitation commenced. ***See also PCSX18: Rehabilitation Assessment (X60).***

Examples:

Emergency admission for intracapsular fracture neck of femur, treated with closed reduction and fixation using dynamic hip screw. Rehabilitation using physiotherapy during same episode.

W24.1 Closed reduction of intracapsular fracture of neck of femur and fixation using nail or screw

Drug addict admitted to rehabilitation unit for assessment. Rehabilitation programme written and patient starts treatment immediately.

U52.1 Delivery of rehabilitation for drug addiction

Patient is admitted solely for the purpose of rehabilitation following a total hip replacement for osteoarthritis of the hip

U50.3 Delivery of rehabilitation for joint replacement

CHAPTER V BONES AND JOINTS OF SKULL AND SPINE
(V01–V70)

Chapter standards and guidance

PChSV1: Levels of spine (V55)
Whenever a code from categories **V22–V70** is assigned a code from category **V55 Levels of spine** must be assigned directly afterwards to indicate the number of levels operated on. When the level of spine is not specified, code **V55.9 Unspecified levels of spine** must be assigned.

It is strongly recommended that coding managers work closely with the relevant orthopaedic surgeons to ensure that this information is clearly documented in the source document to allow accurate assignment of the correct fourth character.

A ‘level of spine’ means either a **vertebra**, a **disc,** or a **motion segment**

Operations carried out on **vertebrae** include:

- Vertebral excision
- Decompression of fractured vertebrae
- Reduction and fixation of fractured vertebrae
- Biopsy of vertebrae.

Laminectomy or laminectomy decompression (not ‘laminectomy approach’) usually does not involve a procedure on the disc, the decompression is the removal of the bone (lamina) and flavum at the back of the spinal canal, however the decompression occurs at disc level. Therefore, a laminectomy decompression is related to a disc level.

Operations carried out on **intervertebral discs** include:

- Disc excision
- Disc replacement
- Foraminoplasty
- Coblation to disc
- Discography.

Operations carried out on **motion segments** (an intervertebral joint consisting of two vertebrae and the intervening disc) include:

- Decompression of vertebra-disc-vertebra sections
- Interspinous process spacer insertions
- Facet joint injections.

Examples:

Kyphoplasty of fracture of vertebra of thoracic spine

V44.5 Balloon kyphoplasty of fracture of spine
V55.9 Unspecified levels of spine
Z66.4 Thoracic vertebra

Kyphoplasty of fractures of second, fifth and tenth vertebrae of thoracic spine (T2, T5 and T10)

V44.5 Balloon kyphoplasty of fracture of spine
V55.3 Greater than two levels of spine
Z66.4 Thoracic vertebra

Primary posterior laminectomy decompression of L4/L5 spine

V25.4 Primary posterior laminectomy decompression of lumbar spine
V55.1 One level of spine

Automated percutaneous mechanical excision of L4/L5 lumbar intervertebral disc under image control

V58.3 Primary automated percutaneous mechanical excision of lumbar intervertebral disc
V55.1 One level of spine
Y53.9 Unspecified approach to organ under image control

Microdiscectomy of L1/L2 and L4/L5 lumbar intervertebral discs and C6/C7 cervical intervertebral disc

V33.7 Primary microdiscectomy of lumbar intervertebral disc
V55.2 Two levels of spine
V29.6 Primary microdiscectomy of cervical intervertebral disc
V55.1 One level of spine

Insertion of L1/2 interspinous process spacer

V28.1 Primary insertion of lumbar interspinous process spacer
V55.1 One level of spine

Posterior instrumented fusion of lumbar L4/5 and thoracic T1/2 and T2/3 motion segment

V40.4 Posterior instrumented fusion of lumbar spine NEC
V55.1 One level of spine
V40.3 Posterior instrumented fusion of thoracic spine NEC
V55.2 Two levels of spine

PChSV2: Discectomy for decompression

When discectomy is performed in order to decompress, only the code that classifies the spinal decompression operation is necessary, as long as the following criteria are met:

- The decompression and discectomy must have been performed on the *same* disc or group of vertebrae or motion segment

  and

- The responsible consultant must have stated that discectomy was performed in order to result in decompression.

Generally speaking, decompression is “removal of pressure” and removal of the disc is a form of decompression. For example, if the cervical spinal cord or cervical spinal nerve roots are compressed anteriorly by a disc or osteophyte, then the most common operation is anterior cervical discectomy (or corpectomy) as an anterior approach to decompress the cord/root.

PChSV3: Instrumented spinal fusions with decompression and bone graft

When a spinal decompression is performed in addition to a spinal fusion and instrumentation procedure, it is **only** necessary to assign an additional code for the spinal decompression if the code description (for the fusion/instrumentation procedure) does not state **both** ‘fusion’ **and** ‘decompression’.

A bone graft (synthetic or allograft) is an integral part of the spinal fusion and instrumentation procedure. Therefore it is **not** necessary to assign an additional OPCS-4 code for the bone graft when it is performed together with spinal fusion and instrumentation. However, in instances where an **autograft** has been used during the fusion and instrumentation procedure, it is necessary to assign an additional OPCS-4 code

from category **Y66 Harvest of bone** to identify the location where the bone was harvested from.

Examples:

Patient admitted for L5/S1 Transforaminal Lumbar Interbody Fusion (TLIF) with posterior decompression of lumbar spine.

V38.6 Primary transforaminal interbody fusion of joint of lumbar spine
V55.1 One level of spine
V25.5 Primary posterior decompression of lumbar spine NEC
V55.1 One level of spine

Posterior lumbar spinal decompression with intertransverse fusion

V25.3 Primary posterior decompression of lumbar spine and intertransverse fusion of joint of lumbar spine.
V55.9 Unspecified levels of spine

Patient admitted for L3/L5 primary anterior lumbar interbody fusion (ALIF) and posterior instrumentation with the use of bone autograft from the right iliac crest

V33.6 Primary anterior excision of lumbar intervertebral disc and posterior instrumentation of lumbar spine
V55.2 Two levels of spine
Y66.3 Harvest of bone from iliac crest
Z94.2 Right sided operation

Image control used for checking position of reduced fractures and the correct siting of fixators

See PCSY7: Approach to organ under image control (Y53, Y68 and Y78).

Coding standards and guidance

There are a number of different techniques used for remodelling of the skull including barrel staving, pi-extension, melon-slicing, rotation, swapping, re-contouring, re-situating and plication. It is not necessary to assign additional codes to identify the specific type of remodelling used.

V02.1 Posterior calvarial release is usually performed as the first stage of a staged procedure and a more substantial remodelling procedure will be performed at a later date. ***See PGCS18: Staged procedures***.

Example:

First stage posterior calvarial release for craniosynostosis, with application of external distractors.

V02.1 Posterior calvarial release
V18.1 Application of external distracters to skull
Y70.3 First stage of staged operations NOC

PCSV1: Temporal bone excision (V05.8)

Temporal bone excision must be coded using the following codes and sequencing:

V05.8 Other specified other operations on cranium
Y05.- Excision of organ NOC
Z63.3 Temporal bone
Z94.- Laterality of operation

PCSV2: LeFort osteotomies (V10.2, V10.3 and V10.4)

The following codes classify LeFort osteotomies:

- **LeFort I – V10.4 Low level osteotomy of maxilla**
- **LeFort II – V10.3 Osteotomy of maxilla involving nasal complex**
- **LeFort III – V10.2 Transorbital subcranial osteotomy of bone of face**

As with all eponyms the coder must ensure that code assignment fully reflects the procedure performed. ***See PRule 8: Surgical eponyms*.**

Example:

LeFort I low level osteotomy of maxilla with application of intermaxillary fixation.

V10.4 Low level osteotomy of maxilla
V11.1 Intermaxillary fixation of maxilla

PCSV3: Repair of craniofacial cleft and reconstruction of cranial and facial bones (V12.3 and V12.4)

When a transcranial and subcranial repair of craniofacial cleft and reconstruction of cranial and facial bones have been performed codes **V12.3 Transcranial repair of craniofacial cleft and reconstruction of cranial and facial bones HFQ** and **V12.4 Subcranial repair of craniofacial cleft and reconstruction of cranial and facial bones HFQ** must both be assigned.

Where excision/resection of encephalocele is performed at the same time as transcranial and/or subcranial repair of craniofacial cleft and reconstruction of cranial and facial bones a code from category **A06 Other excision of lesion of tissue of brain** must be assigned before codes **V12.3** or **V12.4.**

There is no sequencing standard when assigning codes **V12.3** and **V12.4** together, sequencing will usually be based on what was documented first in the patient's medical record.

Code **V17.1 Intermaxillary fixation of mandible** includes the use of eyelet or tie wires. **V17.2 Internal fixation of mandible NEC** includes the use of Champey plates, screws and plates. **V17.3 Extraoral fixation of mandible** includes outside splints, such as halo.

PCSV4: Primary percutaneous endoscopic excision of thoracic intervertebral disc using laser (V31.4)

When **V31.4 Primary percutaneous endoscopic excision of thoracic intervertebral disc** is performed using a laser **Y08.1 Laser excision of organ NOC** must be assigned in addition.

PCSV5: Lumbar interbody fusion (V33.3, V33.6, V38.5, V38.6 and V51.1)

V33.3 Primary anterior excision of lumbar intervertebral disc and interbody fusion of joint of lumbar spine classifies:

- Anterior lumbar interbody fusion (ALIF)
- Stand alone anterior lumbar interbody fusion (STALIF)

- Axial lumbar interbody fusion (AXIALIF). Additional codes for instrumentation must **not** be assigned.

V33.6 Primary anterior excision of lumbar intervertebral disc and posterior instrumentation of lumbar spine classifies:

- Anterior lumbar interbody fusion (ALIF) with posterior instrumentation.

V38.5 Primary posterior interbody fusion of joint of lumbar spine classifies:

- Posterior lumbar interbody fusion (PLIF).

V38.6 Primary transforaminal interbody fusion of joint of lumbar spine classifies:

- Transforaminal lumbar interbody fusion (TLIF).

V51.1 Primary direct lateral excision of lumbar intervertebral disc and interbody fusion of joint of lumbar spine classifies**:**

- Direct lumbar interbody fusion (DLIF)

Additional codes for instrumentation must **not** be assigned when coding these procedures.

When assigning codes from category **V40 Stabilisation of spine** if the instrumented fusion is not stated to be ‘posterior’ it should be **assumed** to be posterior. Posterior instrumented fusion can also be seen documented as postero-lateral instrumented fusion or intertransverse instrumented fusion.

Codes in category **V41 Instrumental correction of deformity of spine** classify instrumented correction of spinal deformities, such as kyphosis and scoliosis, and must not be used to classify instrumented spinal fusions which can be found at category **V40 Stabilisation of spine**.

Code **V41.1 Posterior attachment of correctional instrument to spine** includes ’Harrington rod’ and ‘Hartshill triangle’.

PCSV6: Magnetic adjustment of spinal growing system (V41.6)

Magnetic adjustment of spinal growing system must be coded using the following codes:

V41.6	**Attention to spinal growing system**
V55.-	**Levels of spine**
Y03.6	**Adjustment to prosthesis in organ NOC**

Codes **V41.5 Posterior attachment of spinal growing system**, **V41.6 Attention to spinal growing system** and **V41.7 Surgical distraction of spinal growing system** classify growing/lengthening rods; these are magnetically or surgically adjustable systems that are inserted posteriorly into the spine of younger patients for the treatment of scoliosis. Following insertion these can be elongated at specific intervals by the clinician using either surgical distraction in theatre or more commonly using magnets in an outpatient clinic.

Pain relief procedures

For the standard for the coding of facet joint block ***see PCSA2: Pain relief procedures***.

CHAPTER W OTHER BONES AND JOINTS
(W01–W99, O06–O10, O17–O19, O21–O27, O29, O32, O35, O37-O41, O49, O51)

Chapter standards and guidance

PChSW1: K-wire fixation

K-wire fixation must always be coded as **rigid fixation.** When K-wires are used to augment anchorage of cerclage wires or in skeletal traction, the use of K-wires must not be coded in addition.

Example:

Primary closed reduction and K-wire fixation of right sided fracture of lower end of radius, performed under image intensifier

W24.2 Closed reduction of fracture of long bone and rigid internal fixation NEC
Y53.5 Approach to organ under image intensifier
Z70.5 Lower end of radius NEC
Z94.2 Right sided operation

PChSW2: Arthroscopic procedures (W84.8)

For procedures performed arthroscopically, code **W84.8 Other specified therapeutic endoscopic operations on other joint structure** must only be assigned when:

- There is no specific 4th character endoscopic (arthroscopic) code that classifies the procedure
- There is no specific 4th character open code that classifies the procedure
- There is no **.8 Other specified** code in any other endoscopic or open category that describes the organ or structure on which the procedure is performed

See PGCS1: Endoscopic and minimal access operations that do not have a specific code.

PChSW3: Procedures using multiple types of fixation

If during a fixation procedure more than one type/component of a fixation device has been used (e.g. pin and plate, pins and 'K' wires) only the main part of the device that is holding the fracture together must be coded.

When it is not clear which part of the fixation device is the main part holding the fracture together, advice must be sought from the responsible consultant.

For example, in a fractured femur that is pinned and plated it is the pin that is coded. In an Ilizarov fixator, it is the external part of the device that is holding the fracture, and therefore this is coded as an external fixator.

Types of bone reduction and fixation in the treatment of fractures:

Reduction:

- *Closed* reduction consists of manual manipulation of the fracture and is usually performed in an operating theatre with the use of anaesthesia.
- *Open* reduction includes an open surgical operation for reducing and immobilising the fracture. Complete fracture immobilisation is commonly carried out by combining reduction procedures with various methods of fixation.

Fixation: Biocompatible fixators may be used externally or internally to hold fragments of bone in position until union takes place.

- *Internal* fixation includes inserting screws, plates, pins, wires and nails into the bone to hold the fracture in place. *Intramedullary* and *extramedullary* fixation are both forms of internal fixation.
- *External* fixation involves a fixation device outside of the bone. It includes braces, plates, and fixators such as Ilizarov.

Both external and internal fixation may be performed with either open or closed procedures for fractures.

Intramedullary fixation

Intramedullary fixation is clinically defined as a fixation device where the main part passes longitudinally, inside the length of the medullary canal, found in long bones. Examples of intramedullary fixation devices include intramedullary (IM) nails and Kirschner (K) wires/screws when inserted into the medullary canal of a long bone, e.g. a phalanx.

Adhering to the clinical definition of intramedullary, there are two codes within category **W19** classifying procedures which themselves are not considered intramedullary:

W19.1 Primary open reduction of fracture of neck of femur and open fixation using pin and plate.

W19.4 Primary open reduction of fracture of short bone and fixation using screw

However, to avoid issues such as those relating to data consistency over time and the fragility hip fracture best practice tariff, **W19.1** and **W19.4** should continue to be used where the four-character code description reflects the procedure documented within the medical record.

Any uncertainty regarding the intramedullary nature of a procedure should be referred to the responsible consultant for clarification.

Image control used for checking position of reduced fractures and the correct siting of fixators

See PCSY7: Approach to organ under image control (Y53, Y68 and Y78)

Conversion procedures

See PGCS16: Conversion procedures for standards for coding conversion procedures.

Coding procedures performed for the correction of congenital deformities

See PGCS11: Coding procedures performed for the correction of congenital deformities.

Coding standards and guidance

PCSW12: Osteotomy of the foot

When coding foot osteotomies, the appropriate OPCS-4 category will depend on the method of osteotomy and whether the osteotomy was performed on a single metatarsal, on multiple metatarsals, or on the phalanges.

There are many codes within Chapters W and X that specifically describe different methods of osteotomy, e.g. angulation periarticular osteotomy (**W12.-**) or displacement osteotomy (**W13.2**); these terms must be documented in the patient's medical record and the appropriate index trail must be followed to assign these codes.

Osteotomies are often documented with the use of eponyms: however, the use of eponyms (e.g. Akin osteotomy, Scarf osteotomy) within clinical coding is discouraged. Where an eponym has been used by the responsible consultant and the specific type of osteotomy (e.g. 'displacement', 'periarticular angulation' etc) has also been stated, rather than using the Alphabetical Index of Surgical Eponyms, the clinical coder must assign codes for the specific type of osteotomy using the Alphabetical Index of Interventions and Procedures.

See also PRule 8: Surgical eponyms

Osteotomies of the foot must be coded as follows:

Osteotomy/osteotomies of multiple metatarsals of the same foot

All osteotomy/osteotomies carried out on more than one metatarsal of the same foot must be assigned the following codes, regardless of the method used:

W03.2 Osteotomy of multiple metatarsals or **W03.6 Osteotomy of multiple metatarsals and fixation HFQ**
Z site code(s) (where this adds further information)
Z94.- Laterality of operation

Osteotomy/osteotomies of a single metatarsal, specified method

For osteotomy/osteotomies of a single metatarsal, where the method of osteotomy is specified, the following codes must be assigned. The OPCS-4 Alphabetical Index must be used to assign the appropriate osteotomy code:

W12.- Angulation periarticular division of bone or **W13.- Other periarticular division of bone** or **W14.- Diaphyseal division of bone** or **W77.5 Periarticular osteotomy for stabilisation of joint**
Z site code (where this adds further information)
W28.1 Application of internal fixation to bone NEC, **W28.6 Insertion of intramedullary fixation of bone NEC** or **W30.1 Application of external fixation to bone NEC** (if fixation is used, and is not already implicit in the osteotomy code description)
Z site code (where this adds further information)
Z94.- Laterality of operation

Osteotomy/osteotomies of a single metatarsal, unspecified method

Osteotomy/osteotomies of a single metatarsal, where the method of the osteotomy/osteotomies is not specified, must be coded as follows:

W15.- Division of bone of foot*
Z site code (where this adds further information)
W28.1 Application of internal fixation to bone NEC, **W28.6 Insertion of intramedullary fixation of bone NEC** or **W30.1 Application of external fixation to bone NEC** (if fixation is used, and is not already implicit in the osteotomy code description).
Z site code (where this adds further information)
Z94.- Laterality of operation

***Code **W15.7 Osteotomy of bone of foot and fixation HFQ** must only be assigned when the metatarsal osteotomy cannot be classified to a site specific code in category **W15.-**. If a site specific code is available in category **W15.-**, use the site specific code with code **W28.1, W28.6** or **W30.1**, a Z site code and **Z94**.-.

Osteotomy/osteotomies of phalanx, specified method

For osteotomy/osteotomies of a phalanx, where the method of osteotomy is specified the following codes must be assigned. The OPCS-4 Alphabetical Index must be used to assign the appropriate osteotomy code:

W12.- Angulation periarticular division of bone or **W13.- Other periarticular division of bone** or **W14.- Diaphyseal division of bone** or **W15.6 Cuneiform osteotomy of proximal phalanx with resection of head of first metatarsal** or **W77.5 Periarticular osteotomy for stabilisation of joint**
Z site code (where this adds further information)
W28.1 Application of internal fixation to bone NEC, **W28.6 Insertion of intramedullary fixation of bone NEC** or **W30.1 Application of external fixation to bone NEC** (if fixation is used, and it is not already implicit in the osteotomy code description)
Z Site code (where this adds further information)
Z94.- Laterality of operation

Osteotomy of phalanx, other specified method or unspecified method

Where phalangeal osteotomy is performed and the method specified is not classifiable to one of the categories listed above, assign the following codes:

W15.7 Osteotomy of bone of foot and fixation HFQ (if with fixation) or **W15.8 Other specified other division of bone** (if without fixation)

Z site code (where this adds further information)
Z94.- Laterality of operation

Examples:

Displacement osteotomy of head of 2nd metatarsal bone with internal fixation and osteotomy of 1st metatarsal bone with internal fixation, right foot.

W03.6 Osteotomy of multiple metatarsals and fixation HFQ
Z80.1 First metatarsal
Z80.2 Metatarsal NEC
Z94.2 Right sided operation

Osteotomy with fixation was performed on multiple metatarsals of the right foot.

Displacement osteotomy of second metatarsal, right foot.

W13.2 Displacement osteotomy
Z80.2 Metatarsal NEC
Z94.2 Right sided operation

The specified method of osteotomy has been documented.

Scarf osteotomy of 1st metatarsal bone, internal fixation with two screws and Akin osteotomy of 1st proximal phalanx, fixation with one screw, left foot.

W15.3 Osteotomy of first metatarsal bone NEC
W28.1 Application of internal fixation to bone NEC
Z80.1 First metatarsal
W15.7 Osteotomy of bone of foot and fixation HFQ
Z80.3 Phalanx of great toe
Z94.3 Left sided operation

Osteotomy was performed on a single metatarsal and a phalanx, both of the left foot. The osteotomy methods were not stated, only the eponyms were used.

Closing wedge osteotomy of left proximal phalanx of the great toe, internal fixation with a screw.

W13.3 Cuneiform osteotomy NEC
Z80.3 Phalanx of great toe
W28.1 Application of internal fixation to bone NEC
Z80.3 Phalanx of great toe
Z94.3 Left sided operation

The term '*ossicle*' at code **W08.7 Excision of accessory ossicle** pertains to a small bone and NOT to operations on the ossicles found in the middle ear which are classified within Chapter D.

PCSW1: Secondary reduction and remanipulation of fracture and fracture dislocation

Secondary reduction and remanipulation of fracture/fracture dislocation codes must only be assigned when the patient undergoes further **reduction** or **remanipulation** on the **same** fracture/fracture dislocation site.

The secondary reduction/remanipulation procedure may be the **same** or **differ** from the original procedure. These may be:

- The **same**, for example - primary **open** reduction followed by further **open** reduction or
- **Different**, for example - primary **closed** reduction followed by subsequent **open** reduction, or reduction without fixation followed by secondary reduction with fixation.

Secondary reductions may be performed in a different health facility to the one that the primary reduction was performed in. The primary reduction may have taken place within the A&E department.

Examples:

Patient admitted with fracture of the right lateral malleolus. A closed reduction of the fracture was performed in A&E and a POP cast was applied. The patient went on to have an open reduction and fixation of the right lateral malleolus fracture using extramedullary plate a few days later.
Codes and sequence for the open reduction and fixation of the right lateral malleolus fracture using extramedullary plate are:

W23.2 Secondary open reduction of fracture of bone and extramedullary fixation HFQ
Z78.4 Lateral malleolus
Z94.2 Right sided operation

Patient seen in A&E with fracture of the left distal radius. The patient was treated conservatively with an arm splint. An open reduction and extramedullary fixation using a plate was performed the following morning.
Codes and sequence for the open reduction and fixation of the left distal radius using extramedullary plate are:

W20.1 Primary open reduction of fracture of long bone and extramedullary fixation using plate NEC
Z70.5 Lower end of radius NEC
Z94.3 Left sided operation

Patient has a fracture of the right radius shaft. A closed reduction of the fracture is initially performed in A&E and a POP applied. Six days later the patient is admitted as the fracture has slipped. A further closed reduction is performed under image intensifier.
Codes and sequence for the further closed reduction under image intensifier are:

W26.4 Remanipulation of fracture of bone NEC
Y53.5 Approach to organ under image intensifier
Z70.3 Shaft of radius NEC
Z94.2 Right sided operation

Patient has a fracture of the right radius shaft. The fracture is initially reduced under image intensifier and a POP applied. Six days later the patient is re-admitted as the fracture has slipped. A remanipulation is performed under image intensifier using screw and plate fixation.

O17.6 Remanipulation of fracture of bone and fixation using plate
Y53.5 Approach to organ under image intensifier
Z70.3 Shaft of radius NEC
Z94.2 Right sided operation

PCSW2: Tension band wiring of patella (W21.4)

Tension band wiring of the patella is coded as follows:

W21.4 Primary intra-articular fixation of intra-articular fracture of bone NEC
Z78.7 Patella
Z94.- Laterality of operation

Code **W28.4 Insertion of intramedullary fixation and cementing of bone** will primarily be used in the treatment of bone tumours.

Harvest of bone marrow for autologous transplant (W35.8)

See PCSX8: Bone marrow transplantation and peripheral blood stem cell transplantation

PCSW4: Total hip replacement with acetabular bone graft (W37-W39)

Bone chippings, produced from bone reamed from the patient's acetabulum or femur during a **primary total hip replacement** that are used to **fill defects and secure** the prosthetic joint replacement, must not be coded in addition to the prosthetic joint replacement code(s).

If during a **primary** or **revisional total hip replacement**, an acetabular or femoral bone graft, using either morcellised bone or block of bone, is performed in addition to the joint replacement the following codes must be assigned:

Primary or revisional total prosthetic replacement of hip joint code
W31.- Other autograft of bone or **W32.- Other graft of bone**
Z75.6 Acetabulum or **Z76.- Femur**
Y66.- Harvest of bone (only if an autograft was used)
Z site code of the harvest (if not identified in the code from **Y66.-**)
Z94.- Laterality of operation

Any uncertainty as to whether the joint replacement involves a bone graft, or a packing using bone chippings, must be referred back to the responsible consultant for clarification.

This is an exception to standard ***PGCS12: Coding grafts and harvests of sites other than skin***.

Examples:

Primary uncemented left total hip replacement, the defects around the implant were packed using bone chippings from the reamed bone of the patient's acetabulum:

W38.1 Primary total prosthetic replacement of hip joint not using cement
Z94.3 Left sided operation

Revisional uncemented left total hip replacement with morcellised autograft of bone to fill large acetabular defect. Bone harvested from left iliac crest.

W38.3 Revision of total prosthetic replacement of hip joint not using cement
W31.4 Cancellous chip autograft of bone
Z75.6 Acetabulum
Y66.3 Harvest of bone from iliac crest
Z94.3 Left sided operation

PCSW5: Staged replacement of infected prosthetic joint replacement

For the **first stage** of the procedure assign the following codes:

Attention to prosthetic replacement of relevant joint NEC
Y03.7 Removal of prosthesis from organ NOC
W81.7 Insertion of therapeutic spacer into joint
Y70.3 First stage of staged operations NOC
Z site code
Z94.- Laterality of operation

Debridement must not be coded in addition when a joint spacer has been inserted following removal of the prosthesis.

For the **second stage** of the procedure assign the following codes:

Insertion of like for like prosthesis:

Revision of prosthetic replacement of relevant joint code
Y71.1 Subsequent stage of staged operations NOC
Z94.- Laterality of operation

Insertion of a different type of prosthesis:

Conversion to prosthetic replacement of relevant joint code (new prosthesis inserted during this stage)

Code that classifies conversion from prosthetic replacement of relevant joint (prosthesis removed in stage 1)
Y71.1 Subsequent stage of staged operations NOC
Z94.- Laterality of operation

See also PGCS16: Conversion procedures.

The removal of the joint spacer during the second stage of the procedure must not be coded in addition.

Infected prosthetic joint replacements are commonly treated in two stages.
First the prosthesis is removed, surrounding infected tissue is debrided and an antibiotic 'joint spacer' is inserted. In cases of severe infection, the joint spacer may be replaced prior to the permanent joint replacement.

After the infection has cleared the joint spacer is removed and the new joint prosthesis is inserted, the new prosthesis may be the same type, 'like for like', (for example, cemented to cemented) or a different type (for example, cemented to uncemented) to the prosthesis that was removed during the first stage.

There are no dedicated codes for the removal of prosthetic joint replacements, therefore the relevant 'attention to' codes must be used for the first stage. However, as 'revision' and 'conversion to' codes are available within specific joint replacement categories these are used for the second stage when a new joint replacement is inserted.

Examples:

A patient with an infected left cemented total knee replacement is admitted for the first stage of a two stage replacement. The infected joint replacement is removed. The joint is debrided and a joint spacer is inserted. 6 weeks later they are readmitted for the second stage of the procedure. The joint spacer is removed and a new cemented total knee replacement is inserted:

First stage:

W42.4 Attention to total prosthetic replacement of knee joint NEC
Y03.7 Removal of prosthesis from organ NOC
W81.7 Insertion of therapeutic spacer into joint
Y70.3 First stage of staged operations NOC
Z84.6 Knee joint
Z94.3 Left sided operation

Second stage:

W40.3 Revision of total prosthetic replacement of knee joint using cement
Y71.1 Subsequent stage of staged operations NOC
Z94.3 Left sided operation

A patient with an infected left cemented total hip replacement is admitted for the first stage of a two stage replacement. The infected joint replacement is removed. The joint is debrided and a joint spacer is inserted. 4 weeks later they are readmitted for the second stage of the procedure. The joint spacer is removed and a new uncemented total hip replacement is inserted:

First stage:

W39.4 Attention to total prosthetic replacement of hip joint NEC
Y03.7 Removal of prosthesis from organ NOC
W81.7 Insertion of therapeutic spacer into joint
Y70.3 First stage of staged operations NOC
Z84.3 Hip joint
Z94.3 Left sided operation

Second stage:

W38.2 Conversion to total prosthetic replacement of hip joint not using cement
Note: Use a subsidiary conversion from code as necessary
W37.0 Conversion from previous cemented total prosthetic replacement of hip joint
Y71.1 Subsequent stage of staged operations NOC
Z94.3 Left sided operation

PCSW6: Unicompartmental knee replacement (W58.1)

Unicompartmental knee replacements are coded as follows:

W58.1 Primary resurfacing arthroplasty of joint
Z84.4 Patellofemoral joint or **Z84.5 Tibiofemoral joint** (depending on which surfaces were replaced)
Z94.- Laterality of operation

PCSW13: Patella resurfacing/patella button (W58.1)

When coding patella resurfacing, also known as a patella button procedure, the following codes must be assigned:

W58.1 Primary resurfacing arthroplasty of joint
Z78.7 Patella
Z94.- Laterality of operation

When patella resurfacing/patella button procedure is performed at the same time as a knee joint replacement, these codes must be assigned after the code(s) for the knee joint replacement.

PCSW14: Implantation of stem cells into joint

The implantation of stem cells into a joint must be coded as follows:

W71.5 Open stem cell implantation into articular structure or **W89.3 Endoscopic stem cell implantation into articular cartilage**
Y36.5 Introduction of biological scaffold into organ NOC or **Y36.6 Introduction of synthetic scaffold into organ NOC** or **Y36.7 Introduction of other scaffold into organ NOC** (if a scaffold was used)
Chapter Z site code identifying the implantation site, where this adds further information
Z94.- Laterality of operation (if applicable)
Chapter Y code identifying the type of tissue harvested and the site of harvest
Chapter Z site code identifying the harvest site, where this adds further information
Z94.- Laterality of operation (if applicable)

The harvest of stem cells from bone marrow and the implantation into joint are performed during the same theatre visit. This is a different procedure to blood stem cell harvest and transplantation (***PCSX8: Bone marrow transplantation and peripheral blood stem cell transplantation***).

Example:

Open stem cell implantation into the right knee joint for osteochondral defect. Stem cells harvested from bone marrow from the right iliac wing and suspended in a biological scaffold during the same theatre visit

W71.5 Open stem cell implantation into articular structure
Y36.5 Introduction of biological scaffold into organ NOC
Z84.6 Knee joint
Z94.2 Right sided operation
Y66.7 Harvest of bone marrow

Z75.3 Wing of ilium
Z94.2 Right sided operation

PCSW7: Ozaki procedure (W76.1)

The Ozaki procedure performed using an open approach is coded as follows:

W76.1 Excision of ligament
Z89.1 Shoulder NEC
Z94.- Laterality of operation

The Ozaki procedure performed using an arthroscopic approach is coded as follows:

W76.1 Excision of ligament
Y76.7 Arthroscopic approach to joint
Z89.1 Shoulder NEC
Z94.- Laterality of operation

Release of tennis elbow (T69 or W78)

See PCST1: Release of tennis elbow (T69 or W78)

PCSW8: Autologous chondrocyte implantation into knee joint

The first stage of autologous chondrocyte implantation (ACI) into the knee, when the chondrocytes are harvested, is coded using the following codes:

W89.2 Endoscopic harvest of autologous chondrocytes
Y70.3 First stage of staged operations NOC
Z site code
Z94.- Laterality of operation

The second stage is coded as follows:

Using an open approach:

W71.4 Open autologous chondrocyte implantation into articular structure
Y36.5 Introduction of biological scaffold into organ NOC or **Y36.6 Introduction of synthetic scaffold into organ NOC** or **Y36.7 Introduction of other scaffold into organ NOC** (if a scaffold was used)

Y71.1 Subsequent stage of staged operations NOC
Z site code
Z94.- Laterality of operation

Using an arthroscopic approach:

W85.3 Endoscopic autologous chondrocyte implantation of knee joint
Y36.5 Introduction of biological scaffold into organ NOC or **Y36.6 Introduction of synthetic scaffold into organ NOC** or **Y36.7 Introduction of other scaffold into organ NOC** (if a scaffold was used)
Y71.1 Subsequent stage of staged operations NOC
Z94.- Laterality of operation

PCSW9: Aspiration of prosthetic joint (W90.1)

The aspiration of a prosthetic joint is coded as follows:

W90.1 Aspiration of joint
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control** (if used)
Z site code
Z94.- Laterality of operation

These procedures must not be coded using the ‘attention to’ prosthetic joint replacement procedure codes.

It is not appropriate to assign an ‘attention to’ code for the aspiration of a prosthetic joint. The presence of the prosthesis may be connected to the need for aspiration; however the aspiration is performed on the cavity of the joint, and does not involve the actual physical parts of the prosthesis.

PCSW10: Acromioclavicular joint excision/decompression with subacromial decompression/acromioplasty

Open acromioclavicular joint (ACJ) excision/decompression is classified using the following codes:

W57.2 Primary excision arthroplasty of joint NEC
Z81.2 Acromioclavicular joint
Z94.- Laterality of operation

Arthroscopic ACJ excision/decompression is classified using the following codes:

W84.4 Endoscopic decompression of joint
Z81.2 Acromioclavicular joint
Z94.- Laterality of operation

If ACJ excision/decompression and subacromial decompression/acromioplasty (**O29.1 Subacromial decompression**) are performed then both procedures must be coded. If repair of the rotator cuff muscle (**T79.- Repair of muscle**) is performed in addition to either of these procedures then this must also be coded.

Examples:

Arthroscopic acromioplasty with excision (decompression) of arthritic AC joint right shoulder

O29.1 Subacromial decompression
Includes: Acromioplasty NEC
Note: Use a subsidiary code for minimal access approach (Y74–Y76)
Y76.7 Arthroscopic approach to joint
W84.4 Endoscopic decompression of joint
Z81.2 Acromioclavicular joint
Z94.2 Right sided operation

Open SAD with AC joint excision arthroplasty right shoulder

O29.1 Subacromial decompression
Includes: Acromioplasty NEC
W57.2 Primary excision arthroplasty of joint NEC
Z81.2 Acromioclavicular joint
Z94.2 Right sided operation

Right Arthroscopic SAD with repair of multiple tears of rotator cuff

O29.1 Subacromial decompression
Includes: Acromioplasty NEC
Note: Use a subsidiary code for minimal access approach (Y74–Y76)
Y76.7 Arthroscopic approach to joint
T79.4 Plastic repair of multiple tears of rotator cuff of shoulder
Y76.7 Arthroscopic approach to joint
Z94.2 Right sided operation

PCSW11: Hybrid knee replacement (O18.1)

Hybrid knee replacements are coded as follows:

O18.1 Primary hybrid prosthetic replacement of knee joint using cement
Z77.1 Condyle of tibia or Z76.5 Lower end of femur NEC (depending on the component that is cemented)
Z94.- Laterality of operation

Usually, a hybrid knee replacement has a cemented tibial component and an uncemented femoral component. However it is possible to have a hybrid knee replacement with a cemented femoral component and an uncemented tibial component.

Category **O32 Total prosthetic replacement of ankle joint** classifies all total prosthetic replacement of ankle joint whether cemented, uncemented or unspecified.

CHAPTER X MISCELLANEOUS OPERATIONS (X01–X98)

Chapter standards and guidance

Coding procedures performed for the correction of congenital deformities
See PGCS11: Coding procedures performed for the correction of congenital deformities

Coding standards and guidance

PCSX26: Reamputation (X12.1)
X12.1 Reamputation at higher level must only be assigned when a further amputation is performed on the same arm or leg as the original amputation, i.e. where there has been a previous amputation above the level of the hand or foot. This is regardless of the bone of the arm or leg that was originally amputated. Where amputation involving the arm or leg is performed after a previous amputation of the fingers, hand, toes, or foot, this must be coded as a new amputation of the arm or leg. A further amputation of the hand or foot must be coded using a code from category **X08 Amputation of hand**, **X10 Amputation of foot** or **X11 Amputation of toe**, rather than **X12.1.**
Amputations are clinically categorised as either minor or major. A minor amputation is any amputation of the finger, hand, toe, or foot. Major amputations are those which involve the arm or leg. **X12.1 Reamputation at higher level** describes a further major amputation, it does not include: • a major amputation following a minor amputation • a subsequent minor amputation

Examples:

Patient has previously undergone a right above knee amputation (AKA). The stump becomes infected and a further three inches of the femoral shaft are amputated.

X12.1 Reamputation at higher level
Z76.4 Shaft of femur
Z94.2 Right sided operation

Patient has previously undergone an amputation of great toe of the left foot due to diabetic ulcer. The ulcer reoccurs in the foot and a further amputation is performed through the metatarsal bones (transmetatarsal amputation).

X10.4 Amputation through metatarsal bones
Z94.3 Left sided operation

Patient has previously undergone a right below knee amputation (BKA) due to necrosis of the foot. Following amputation the necrosis reoccurs in the leg and a further amputation is performed above the knee.

X12.1 Reamputation at higher level
Z76.9 Femur NEC
Z94.2 Right sided operation

PCSX2: Intravenous infusions and intravenous injections

Intravenous (IV) infusions and IV injections must ***only*** be coded if the patient is admitted solely for administration of the IV infusion or injection.

The exceptions are **Parenteral nutrition as described in *PCSX24: High Cost Drugs (X81–X98)*** and ***PCSX25: Administration of thrombolytic/fibrinolytic drugs and alteplase.***

Example:

Patient being treated for epilepsy develops a chest infection during the hospital provider spell and is administered IV antibiotics.

No OPCS-4 code is assigned as the patient was not admitted solely for administration of the IV antibiotics.

Anti-D injection during pregnancy and following delivery (X30.1)

See PCSR8: Anti-D injection during pregnancy and following delivery (X30.1).

PCSX4: Blood transfusions (X33)

Only if the patient is admitted solely for the purpose of a blood transfusion (**X33**) must the transfusion be coded. Blood transfusions given during surgery, e.g. major bowel surgery, transplants, joint replacements etc must not be coded.

*The exceptions are **PCSX5: Intraoperative blood salvage and transfusion (X33.7 and X36.4) and X33.4-X33.6 in PCSX8: Bone marrow transplantation and peripheral blood stem cell transplantation.***

PCSX5: Intraoperative blood salvage and transfusion (X33.7 and X36.4)

Code **X36.4 Autologous blood salvage** must only be used in a secondary position.

When intraoperative blood (cell) salvage and reinfusion of the salvaged blood cells into the patient has been performed during a procedure, the following codes must be assigned in addition to the code(s) classifying the procedure during which the cells were salvaged:

X36.4 Autologous blood salvage
X33.7 Autologous transfusion of red blood cells

Where intraoperative blood (cell) salvage has been performed during a procedure and the salvaged blood has not been reinfused during the procedure, the following code must be assigned in addition to the code(s) classifying the procedure during which the cells were salvaged:

X36.4 Autologous blood salvage

Where reinfusion of salvaged blood has been performed after the procedure when intraoperative blood (cell) salvage was performed, the following code must be assigned:

X33.7 Autologous transfusion of red blood cells

*This is an exception to the standard to only code blood transfusions if the patient is admitted solely for the purpose of the blood transfusion in **PCSX4: Blood transfusions (X33).***

PCSX6: Intravenous induction of labour (X35.1)

Code **X35.1 Intravenous induction of labour** must never be used. Codes within Chapter R categories **R14 Surgical induction of labour** and **R15 Other induction of labour** must be used to code induction of labour.

PCSX7: Red Cell Survival procedure (X35.8)

Red Cell Survival procedure must be coded using:

X35.8 Other specified other intravenous injection

Diagnostic blood tests (X36.3, X36.8, X36.9 and U32.1)

See PCSU6: Diagnostic blood tests (U32.1, X36.3, X36.8 and X36.9).

PCSX8: Bone marrow transplantation and peripheral blood stem cell transplantation

Bone marrow harvest and transplantations must be coded as follows:

- Harvest of allogeneic or syngeneic bone marrow:

  X46.1 Donation of bone marrow
  Z75.3 Wing of ilium or **Z74.2 Sternum NEC** (depending on site of harvest)
  Z94.- Laterality of operation (if appropriate)
- Harvest of autologous bone marrow:

  W35.8 Other specified therapeutic puncture of bone
  Y66.7 Harvest of bone marrow
  Y70.3 First stage of staged operations NOC
  Z75.3 Wing of ilium or **Z74.2 Sternum NEC** (depending on site of harvest)
  Z94.- Laterality of operation (if appropriate)

- A code from category **W34 Graft of bone marrow** is assigned on the episode of care in which the bone marrow is transplanted into the recipient patient. – See ***PGCS12: Coding grafts and harvest of sites other than skin***.

Peripheral blood stem cells (PBSC) harvest and transplantation must be coded as follows:

Allogeneic or syngeneic

- Harvest of allogeneic or syngeneic peripheral blood stem cells:

  X36.1 Blood donation
  Y69.8 Other specified harvest of other tissue

- Allogeneic or syngeneic transplant of peripheral blood stem cells:

X33.5 Syngeneic peripheral blood stem cell transplant or **X33.6 Allogeneic peripheral blood stem cell transplant**
Y99.- Donor status (where doing so adds further information)

Autologous

- Harvest of autologous peripheral blood stem cells, when performed during a separate consultant episode to the transplantation:

  X36.1 Blood donation
  Y69.8 Other specified harvest of other tissue
  Y70.3 First stage of staged operations NOC

- Autologous transplant of peripheral blood stem cells into the recipient patient, when performed during a separate consultant episode to the harvest:

  X33.4 Autologous peripheral blood stem cell transplant
  Y71.1 Subsequent stage of staged operation NOC

- Autologous peripheral blood stem cells harvested and transplanted during the same consultant episode:

  X33.4 Autologous peripheral blood stem cell transplant

*This is an exception to **PCSX4: Blood transfusions (X33)** to only code blood transfusions when the patient is admitted solely for the purpose of the blood transfusion.*

In **autologous transplants** patients receive their own stem cells or bone marrow.

In **syngeneic transplants** patients receive stem cells or bone marrow from their **identical** twin.

In **allogeneic transplants** (where 'allogeneic' means 'coming from the same species but genetically dissimilar'), patients can receive stem cells or bone marrow from their brother or sister (which would include non-identical twins) or parent. Cells from a person who is not related to the patient (an unrelated donor) may also be used.

PCSX9: Compensation for renal failure (X40)

A code from category **X40 Compensation for renal failure** must be assigned every time an intervention classified to this category is performed. Any procedure(s) performed in order to carry out a procedure classifiable to category **X40**, such as insertion of dialysis catheters, central venous catheters, arteriovenous shunts, etc. must also be coded, with the code from **X40** being sequenced after these other procedures.

PCSX10: Administration of vaccine (X44)

Codes in category **X44 Administration of vaccine** must only be assigned if the patient is admitted solely for the purpose of vaccination.

PCSX11: Donation of organ (X45)

The donation of organs must only to be coded, using a code from category **X45 Donation of organ**, if the patient donating the organs is alive.

The removal of organs for donation from ‘brain dead’ or ’deceased’ patients must not be coded.

PCSX12: Donation of skin (X46.2)

Donation of skin is coded as follows:

X46.2 Donation of skin
Y harvest code
Site and laterality code (if necessary)

See PCSS3: Coding of skin grafts and harvests

Example:

Donation of random pattern flap of skin from back

X46.2 Donation of skin
Y56.2 Harvest of random pattern flap of skin from back

PCSX13: Low-density lipoprotein apheresis (X47.1)

X47.1 Low-density lipoprotein apheresis must be coded each time it is carried out.

PCSX15: Evaluation of cardioverter defibrillator (X50.5)

Code **X50.5 Evaluation of cardioverter defibrillator** must not be assigned when evaluation/testing is performed during the insertion of the cardioverter defibrillator.

PCSX16: Extracorporeal membrane oxygenation (X58.1)

X58.1 Extracorporeal membrane oxygenation must be coded every time it has been performed.

PCSX17: Anaesthetic without surgery (X59)

Codes in category **X59 Anaesthetic without surgery** must only be used to classify patients who receive a general or spinal anaesthetic, but subsequently do not undergo any procedure or intervention.

See PCSY10: Anaesthetic (Y80–Y84).

The type of anaesthetic given (i.e. general or spinal) may be coded in addition to **X59.-** if this information is required to be collected locally.

Example:

Lumbar epidural anaesthetic, no other procedure performed

X59.8 Other specified anaesthetic without surgery
Y81.1 Epidural anaesthetic using lumbar approach

PCSX18: Rehabilitation Assessment (X60)

When an assessment for rehabilitation, accompanied by a written report, is carried out by a **team from two or more clinical professions within local therapy/support services** assign:

X60.1 Rehabilitation assessment by multidisciplinary non-specialised team

When an assessment for rehabilitation, accompanied by a written report, is carried out by a **team from two or more clinical professions within district specialist service(s)** assign:

X60.2 Rehabilitation assessment by multidisciplinary specialised team

When an assessment for rehabilitation, accompanied by a written report, is carried out by a **team (or individual) from a single clinical profession within local therapy/support services** assign:

X60.3 Rehabilitation assessment by unidisciplinary non-specialised team

When an assessment for rehabilitation, accompanied by a written report, is carried out by a **team (or individual) from a single clinical profession within district specialist service(s)** assign:

X60.4 Rehabilitation assessment by unidisciplinary specialised team

See PCSU7: Rehabilitation (U50-U54) - Where a patient receives rehabilitation assessment (**X60**) and actual rehabilitation (**U50–U54**) within the *same* hospital provider spell, only one code is required from within the range **U50–U54**

PCSX19: Assessment (X62)

The codes at category **X62 Assessment** must only be used in an outpatient setting.

PCSX20: Radiotherapy (X65, X67–X69)

Preparation for radiotherapy

Preparation for radiotherapy is coded as follows:

X67.- **Preparation for external beam radiotherapy** or **X68.- Preparation for brachytherapy**
Y92.- **Support for preparation for radiotherapy** (if used)

Code **Y92.1 Technical support for preparation for radiotherapy** includes the manufacture of patient specific devices generally undertaken in the ‘mould’ room. These are typically immobilisation devices such as impression and shell fitting, lead cut-outs, mouth bites and beam shaping devices.

Preparation codes must:

- be used for **both** inpatient and outpatient activity
- only be assigned **once**, per prescription, to cover **all** planning for each prescription*
- be assigned on the first attendance/episode for delivery of radiotherapy
- be sequenced before the delivery codes.

*There may be instances where the original prescription needs adjusting so is therefore stopped and a new prescription is created. In this case, a new preparation code is assigned for the new prescription on the first attendance/episode for delivery of the new radiotherapy.

Delivery of radiotherapy

Delivery of radiotherapy must be coded as follows:

A-W Body system chapter radiotherapy code (where a body system chapter code that classifies radiotherapy is available)*

- **X65.- Radiotherapy delivery** or **X69.- Other radiotherapy**
- **Y35.- Introduction of removable radioactive material into organ NOC** or **Y36.- Introduction of non-removable material into organ NOC** or **Y91.- External beam radiotherapy** or **O44.- Other external beam radiotherapy**
- **Y89.- Brachytherapy** (assigned with **Y35.-** or **Y36.-** if applicable)
- **Y53.- Approach to organ under image control** or **Y68.- Other approach to organ under image control** (if used)
- **Y80.- General anaesthetic** (if radiotherapy was delivered under anaesthetic)
- Z site code (to identify the area being treated by the radiotherapy, if not already identified by the body system code).

***Where a body system chapter code that classifies radiotherapy is **not** available a code from **X65 Radiotherapy delivery** or **X69 Other radiotherapy** is assigned without a preceding body system code.

When coding radiotherapy delivery:

- Code **X65.9 Unspecified radiotherapy delivery** must only be used when the method of radiotherapy delivery is not classifiable to any of the other fourth-characters within the category. An additional code from category **Y91 External beam radiotherapy** or **O44 Other external beam radiotherapy** must NOT be assigned with code **X65.9**
- For outpatients and daycases, radiotherapy delivery **must** be coded every time a fraction is given
- For inpatients, radiotherapy delivery must only be coded once per prescription, per hospital provider spell, regardless of the number of fractions in each prescription.

Codes **X65.5 Oral delivery of radiotherapy for thyroid ablation** and **X65.7 Delivery of radionuclide therapy NEC** do not require the addition of a code from categories **Y35**, **Y36**, **Y89**, **Y91** or **O44**.

See also:

- ***PCSA8: Stereotactic radiosurgery of cranial nerves and intracranial arteriovenous malformation (A10.7)***
- ***PCSJ1: Selective internal radiotherapy (SIRT) of liver using microspheres (J12.3)***
- ***PCSM9: Radioactive seed implantation into prostate (M70.6).***

A radiotherapy prescription specifies a dose and fractionation for a series of identical treatments. This is similar to a medical prescription. Different anatomical sites treated concurrently would have separate prescriptions.

Codes within category **X67 Preparation for external beam radiotherapy** are divided into 'simple' and 'complex'. Clinical Coding Departments must liaise with clinical staff to determine what actual techniques would fall into these two categories, but for information purposes advice is given in the OPCS-4 supplementary information.

Examples:

Preparation and delivery of pulsed dose brachytherapy therapy for prostate cancer

X68.3 Preparation for interstitial brachytherapy
M71.2 Implantation of radioactive substance into prostate
X65.3 Delivery of a fraction of interstitial radiotherapy
Note: Use a subsidiary code to identify introduction of radioactive material (Y35, Y36)
Note: Use a subsidiary code to identify brachytherapy (Y89)
Y35.4 Introduction of radioactive substance into organ for brachytherapy NOC
Y89.2 Pulsed dose rate brachytherapy treatment

Preparation and delivery of percutaneous intraluminal brachytherapy (using removable radioactive material) to bile duct cholangiocarcinoma using fluoroscopic control

X68.1 Preparation for intraluminal brachytherapy
J48.7 Percutaneous brachytherapy of lesion of bile duct
Note: Use an additional code to specify radiotherapy delivery (X65)
Note: Use a subsidiary code to identify method of image control (Y53)
X65.6 Delivery of a fraction of intraluminal brachytherapy
Note: Use a subsidiary code to identify introduction of radioactive material (Y35, Y36)
Y35.4 Introduction of radioactive substance into organ for brachytherapy NOC
Y53.4 Approach to organ under fluoroscopic control

Preparation and delivery of external beam radiotherapy to lesion of peripheral nerve

X67.- Preparation for external beam radiotherapy
A61.3 Radiotherapy to lesion of peripheral nerve
Note: Use an additional code to specify radiotherapy delivery (X65)
X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.9 Unspecified external beam radiotherapy

Simple preparation using imaging and dosimetry and delivery of simple external beam radiotherapy for adenocarcinoma of prostate using linear accelerator (megavoltage machine)

X67.4 Preparation for simple radiotherapy with imaging and dosimetry
X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.2 Megavoltage treatment for simple radiotherapy
Z42.2 Prostate

Preparation and delivery of hypofractionated stereotactic external beam radiotherapy to lesion of lung

X67.- Preparation for external beam radiotherapy
X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.5 Megavoltage treatment for hypofractionated sterotactic radiotherapy
Z24.6 Lung

Pelvic side wall clearance and intraoperative electron beam radiotherapy for cervical adenocarcinoma under intravenous general anaesthetic

X14.4 Pelvic side wall clearance
X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.6 Intraoperative electron beam radiotherapy
Y80.4 Intravenous anaesthetic NEC
Z45.1 Cervix uteri

Delivery of simple external beam radiotherapy as an inpatient to the left femur on Day 1 and to the pelvic bone on Day 4 in the same hospital admission (separate prescriptions)

Day 1:

X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.2 Megavoltage treatment for simple radiotherapy
Z76.9 Femur NEC
Z94.3 Left sided operation

Day 4:

X65.4 Delivery of a fraction of external beam radiotherapy NEC
Note: Use a subsidiary code to identify external beam radiotherapy (Y91)
Y91.2 Megavoltage treatment for simple radiotherapy
Z75.9 Bone of pelvis NEC

PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)

Only delivery of chemotherapy codes from categories **X72** and **X73** are required for national reporting purposes. The collection of codes classifying procurement is not required, therefore codes from categories **X70** and **X71** should not be assigned unless there is a local requirement to do so.

The codes within categories **X72-X73** must be used in combination with the National Tariff Chemotherapy Regimens List 2017-18.

Codes in categories **X72-X73** must **only** be assigned for systemic anti-cancer therapy for the treatment of malignant or in-situ neoplasms. Where a drug that appears on the chemotherapy regimens list is used for the treatment of **non-neoplastic/non-malignant** diseases and conditions, these must not be classified using codes from **X72-X73,** codes from elsewhere within OPCS-4 can be assigned where appropriate.

The following codes must be assigned when coding the delivery of chemotherapy regimens, regardless of attendance type:

- Delivery code from categories **X72** or **X73** on the first day or attendance of any cycle of a chemotherapy regimen (including when a cycle of the same regimen is repeated)

  In cases where a combination of regimens is prescribed, a delivery code for *each* regimen must be assigned, even if this results in assignment of the same delivery code more than once.

- Delivery code **X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm** on subsequent days or attendances for the *same* cycle (including subsequent attendances for a repeated cycle).

  This is a generic code that applies to all subsequent deliveries of chemotherapy within a cycle.

Regimens identified by “N/A” in the ‘delivery OPCS’ column of the National Tariff Chemotherapy Regimens List must be coded using **X72.9 Unspecified delivery of chemotherapy for neoplasm** on the first day or attendance and **X72.4** on subsequent days or attendances.

Some regimens are very similar and may only differ in the dosage of a drug(s) or in the number of days in the cycle. Therefore, any regimen in the medical record that differs from the Regimen Name in the National Tariff Chemotherapy Regimens List must be queried and clarified in the medical record by the responsible consultant.

It is vital to accurately identify when a new treatment cycle is starting and when a subsequent element of an existing cycle is given; clarification must be sought from the responsible consultant when this is not clear.

When the responsible consultant changes the cycle length, the delivery code will remain the same but must not be coded as a new cycle until the responsible consultant confirms commencement of a new cycle.

Where a regimen labelled as an adult regimen is prescribed for a paediatric patient, the code(s) for the adult regimen must be assigned, and vice versa when a regimen labelled as a paediatric regimen is prescribed for an adult patient.

Missing Chemotherapy Regimens

If a regimen name does not appear on the National Tariff Chemotherapy Regimens List, first check with the responsible consultant as it may be that they recognise the drugs used and call them by a different regimen name, or it may be that it is an adult clinical trial (*see below*). Do not code a different regimen from the one in the medical notes unless a responsible consultant has verified it is the same regimen.

If a regimen is still identified as missing from the list:

- Assign the delivery code **X72.9 Unspecified delivery of chemotherapy for neoplasm**
- On subsequent days or attendances for the same cycle assign **X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm**

The exception to this is oral chemotherapy; if an oral chemotherapy regimen is identified as being missing from the list this must be coded using **X73.1 Delivery of exclusively oral chemotherapy for neoplasm**.

Chemotherapy Trials

Where an adult clinical trial consists of a listed regimen with added trial drug(s) then only the existing regimen is coded. The additional trial component(s) must not be coded.

Adult clinical trial drugs **must not** be coded using OPCS-4 codes at categories **X72-X73** and they **must not** be classified as missing chemotherapy regimens. If the patient attends solely for the purpose of receiving the trial drugs the IV injection or infusion must be coded using the relevant OPCS-4 code.

Paediatric regimens are the exception as they **do** include cancer research trials, and additionally specify the component drugs in the regimen.

See also:

- ***PRule 11: National Tariff Chemotherapy Regimens List***
- ***PCSX28: Route of administration of chemotherapy for neoplasm***
- ***PCSX29: Supportive care therapies related to cancer treatment***
- ***PCSX30:* Other chemotherapy drugs *(X74)***
- ***PCSX31: Chemo-radiation/chemo-radiotherapy***
- ***PCSY14: Electrochemotherapy/electroporation (Y12.3)***

Regimen

A regimen describes in full the name, drugs, doses, route and time of delivery of a specified systemic anti-cancer therapy. Each regimen has a code for procurement and the majority of regimens also have a code for delivery (administration) of the chemotherapy drug(s).

Some hospitals deliver regimens as inpatients and some deliver them as day cases or outpatients: however, there are some chemotherapy regimens that can only be administered as part of an inpatient consultant episode. These regimens are identified by “N/A” in the delivery OPCS-4 column.

Each regimen name is followed by its component drugs. Some regimens can have the same name and are shown more than once on the list: this is because the drug dosing ranges for one or more of the component drugs can be different. When this is the case the

drug dosage is also specified alongside the component drugs on the list. This is important, as the delivery codes may be different.

Where acronyms are used for Regimen names these have also been used in the list. The long and short versions of the regimen names are shown in separate columns on the list.

The addition of a supplementary drug to a regimen, such as Rituximab, is always listed either at the end or the beginning of the regimen name; e.g. CHOP becomes CHOP R, CVP becomes CVP R, ICE becomes ICER. These same regimens may also be found documented in the medical record as RCHOP, RCVP and RICE.

Clinical coding departments should discuss and agree with the responsible oncology team members (oncologists, haematologists and pharmacists) how regimens will be documented, as the Regimens List should not be used alone without clinical consensus. The National Tariff Chemotherapy Regimens List should be given to the responsible oncology team members to help them decide which regimen names they use locally, to enable the coding department to apply the corresponding codes.

If electronic prescribing systems for systemic anti-cancer therapy (SACT) are used to collate coding information and attendances, then the responsible oncology teams and coding departments should be involved in the mapping of the relevant codes to the individual regimens contained within the electronic prescribing system.

The main challenges are to agree regimen names, cycle length for all regimens, and the correct use of code **X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm**.

Cycle

All chemotherapy regimens have a number of days listed for the usual cycle length. The usual cycle length refers to the total number of days in a cycle, *including the rest days*, and is an indicative figure showing when the delivery code should next be coded. Sometimes the regimen specifies that the treatment should be repeated a number of times; each of these repetitions is called a cycle. The cycle could last from a few days in duration to months, so this should be verified locally for each regimen.

Sometimes the responsible consultant will decide to change the cycle length in the best interests of the patient. This is especially the case with haematology cancers, as the cycle lengths often depend on white blood cell levels (blood count) recovering between administrations.

The price bands for long term regimens (e.g. those that have a usual cycle length of 12 months) have been calculated per month, e.g. Hydroxycarbamide. There are only a small number of chemotherapy regimens that last for months and are not cyclical. If there is any uncertainty the coder must check with the responsible consultant.

Attendance

An attendance describes each time the patient visits the hospital as an inpatient, outpatient or day case.

Adult and paediatric regimens

There is variability among names of adult regimens in the UK, so expect there to be variations to the names of regimens and drugs at different sites across the UK. Check under both letters when two drugs are named, e.g. Vinorelbine (IV) + Carboplatin is listed under Carboplatin + Vinorelbine IV.

Paediatric regimens have more complex names than adult regimens and require extra caution. Paediatric regimens tend to have a larger number of cycles over a longer period. The regimen name is listed after the trial name, e.g. FLAG + Idarubicin is an adult regimen and AML Interim Guidelines FLA-Ida is a paediatric regimen. Paediatric regimens include cancer research trials, and additionally specify the component drugs in the regimen.

Each regimen is labelled as either adult or paediatric; this indicates their most common usage. However, some regimens can be prescribed for both adult and paediatric patients.

Combinations of regimens

All regimens are listed separately in the chemotherapy regimens list. Combinations of regimens are not included. There is no national standard for which regimen should be sequenced first when coding combinations of regimens, however this will usually be the first documented in the patient's medical record.

Chemotherapy trials

Adult cancer research is in general excluded from HRGs and the national tariff, with the exception of paediatric regimens. Standard treatment arms and standard components of experimental regimens are included. Where a trial consists of a listed regimen with added trial drug(s) then the additional component will be paid for by the drug company, research organisation or through other identified funding and must not be coded.

Examples:

A breast cancer patient attending as an outpatient receives Trastuzumab IV 7-day loading dose followed by Trastuzumab IV7 day maintenance dose on a weekly basis. This is repeated every seven days.

Cycle 1, Trastuzumab IV 7-day loading dose (outpatient)

X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance

Cycle 2, Trastuzumab IV 7-day maintenance dose (outpatient)

X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance

The loading and maintenance doses are two different chemotherapy regimens, so both require coding. Code **X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm** must **not** be used because each attendance is for the start of a new cycle; both are given at seven-day cycle intervals as specified in the regimen list.

A lymphoma patient is receiving adult regimen ABVD. This consists of four drugs (Doxorubicin, Vinblastine, Bleomycin and Dacarbazine) and is administered every 14 days during daycase attendances.

Cycle 1, ABVD (daycase)

X72.2 Delivery of complex parenteral chemotherapy for neoplasm at first attendance

The delivery code must be repeated for the first attendance of each new cycle, i.e. the code is repeated every 14 days as this is the cycle length stated in the table. Even when the second attendance is locally referred to as “subsequent” or labelled 1b, the codes are repeated every 14 days.

An inpatient is prescribed adult BEP 5-day chemotherapy for a testicular solid tumour. The chemotherapy consists of three different drugs (Etoposide, Cisplatin and Bleomycin) these are administered during an inpatient episode, and then on two consecutive outpatient treatments which are given at seven-day intervals. The whole cycle is repeated every 21 days.

Day 1, Cycle 1, BEP 5 day (inpatient)

X72.1 Delivery of complex chemotherapy for neoplasm including prolonged infusional treatment at first attendance

Day 8, Cycle 1, BEP 5 day (outpatient)

X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm

This is the first subsequent attendance within the cycle; therefore, the **X72.4** delivery code is assigned.

Day 15, Cycle 1, BEP 5 day (outpatient)

X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm

This is the second subsequent attendance within the cycle; therefore, the **X72.4** delivery code is assigned.

Days 16 to 21 = rest day

Day 1, Cycle 2, Bep 5 day (inpatient)

X72.1 Delivery of complex chemotherapy for neoplasm including prolonged infusional treatment at first attendance

Day 1 of the second cycle is coded in the same way as day 1 of the first cycle. Days 8 and 15 of the second cycle would also be coded the same as Days 8 and 15 of the first cycle.

A patient with Hodgkin lymphoma is receiving the CHLVPP regimen as an outpatient. This consists of one day of treatment with Vinblastine, intravenously with a saline infusion. The patient is also given a two-week course of Chlorambucil, Procarbazine and Prednisolone, all taken as tablets at home. On Day 8 of each cycle, the patient returns as an outpatient to receive a subsequent treatment with Vinblastine.

Day 1, cycle 1, CHLVPP (intravenous Vinblastine and saline infusion as outpatient and Chlorambucil, Procarbazine and Prednisolone orally at home).

X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance

On day 1 the oral component of the regimen must not be coded; where a regimen includes oral and parenteral administrations, the parenteral administration will determine the delivery code used.

Day 8, cycle1, Vinblastine (outpatient)

X72.4 Delivery of subsequent element of cycle of chemotherapy for neoplasm

Day 8 is a subsequent element of treatment within the cycle, therefore **X72.4** is assigned.

A breast cancer patient is prescribed FEC-T, this consists of 3 concurrent cycles of FEC 100, once completed this is then followed by 3 cycles of Docetaxel 100mg.

Day 1, Cycle 1, 2, 3 FEC 100 and Day 1, Cycle 1, 2, 3 Docetaxel 100mg

X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance

X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance

PCSX28: Route of administration of chemotherapy for neoplasm

Where chemotherapy is administered intrathecally (into the cerebrospinal fluid in the spinal cord), intravesically (into the bladder) or intracavitarily (into a body cavity) a body system chapter code that classifies the route of administration must be sequenced before the relevant delivery code in category **X72.- Delivery of chemotherapy for neoplasm**. The following codes and sequencing must be assigned:

Intravesical administration of chemotherapy

M49.4 Introduction of therapeutic substance into bladder
X72.- Delivery of chemotherapy for neoplasm

Intrathecal administration of chemotherapy

A54.2 Injection of therapeutic substance into cerebrospinal fluid
X72.- Delivery of chemotherapy for neoplasm

Where a patient receives a chemotherapy regimen that contains a component drug which is administered via intrathecal injection, this must be coded in addition to the codes for the main regimen itself. Whilst the intrathecal drug may be listed as a component drug of the main regimen, the intrathecal drug delivery codes are listed separately to the main regimen. They may be administered on the same day as the main regimen drugs or at a separate attendance.

Intracavitary administration of chemotherapy

Body system chapter code classifying introduction/injection of therapeutic or cytotoxic substance into a body cavity
X72.- Delivery of chemotherapy for neoplasm

If a regimen includes both oral (via the mouth) and parenteral administration (via a route other than the mouth or rectum, i.e. via infusion, injection or implantation), the parenteral administration will determine the delivery code.

X73.1 Delivery of exclusively oral chemotherapy for neoplasm must only be assigned when all of the drugs in a regimen are delivered orally, except in the case of regimens where one or more of the listed components is delivered intrathecally; whilst the intrathecal drug is listed as a component drug of the main regimen, the intrathecal delivery codes are

listed with separate delivery codes to the main regimen. **X73.1** must therefore still be assigned in these instances along with the body system chapter code for method of delivery plus the delivery code for the intrathecal component.

X73.1 must only be assigned once; on the attendance where the patient is given the drug(s) to take home and receives counselling and advice on taking the drug at home.

See also:

- ***PRule 11: National Tariff Chemotherapy Regimens List***
- ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)***
- ***PCSX29: Supportive care therapies related to cancer treatment***
- ***PCSX30:* Other chemotherapy drugs *(X74)***
- ***PCSX31: Chemo-radiation/chemo-radiotherapy***
- ***PCSY14: Electrochemotherapy/electroporation (Y12.3)***

Oral chemotherapy regimen prescriptions may be given to a patient for a period of up to three months before the patient needs to be reviewed. The patient will receive counselling and advice on how to take all of the prescribed cycles of the regimen at home during the same attendance by a responsible consultant, a pharmacist or a specialist chemotherapy practitioner; this will usually be within the oncology unit.

Examples:

A patient with transitional cell carcinoma (TCC) of the bladder attends as a day case on the first day of the first cycle for installation of intravesical Mitomycin chemotherapy.

Day 1, Cycle 1, Mitomycin intravesical (day case)

M49.4 Introduction of therapeutic substance into bladder
Includes: Instillation of therapeutic substance into bladder
X72.2 Delivery of complex parenteral chemotherapy for neoplasm at first attendance

Code **M49.4** must be assigned to classify an intravesical installation followed by the appropriate chemotherapy regimen code from category **X72**

A patient is prescribed eight cycles of adult regimen CHOP-R 21 which is administered as a day case. On day 2 of each cycle the patient receives intrathecal methotrexate also administered as a day case.

Day 1, Cycle 1, CHOP-R 21 days (day case)

X72.2 Delivery of complex parenteral chemotherapy for neoplasm at first attendance

Day 2, Cycle 1, Methotrexate intrathecal (day case)

A54.2 Injection of therapeutic substance into cerebrospinal fluid
X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance

Code **A54.2** must be assigned to classify an intrathecal injection, followed by the appropriate chemotherapy regimen code from category **X72**.

A patient attends the outpatient haemato-oncology clinic and is prescribed 3 cycles of Hydroxycarbamide, the patient receives counselling and advice by a specialist haemato-oncologist and is given a 3-month supply of the drug to take at home.

X73.1 Delivery of exclusively oral chemotherapy for neoplasm

PCSX24: High Cost Drugs (X81-X98)

There is no national requirement to collect OPCS-4 High Cost Drugs data using codes in categories **X81-X98,** with the exception of:

- **X83.3 Fibrinolytic drugs Band 1** when alteplase is given in the treatment of acute stroke, ***see PCSX25: Administration of thrombolytic/fibrinolytic drugs and alteplase***
- **X90.4 Intravenous nutrition Band 1** which must be assigned once on every episode that a patient receives parenteral nutrition, regardless of the number of days this is given.
- **X89.2 Monoclonal antibodies Band 2** which must be assigned when neutralising monoclonal antibodies are administered for the treatment of COVID-19

High cost drugs used for systemic anti-cancer therapy for the treatment of malignant/in-situ neoplasms must be coded, where applicable, using the National Tariff Chemotherapy Regimens list.

see PCSX21 Procurement and delivery of drugs for chemotherapy for neoplasm (X70–X74) and PCSX27: Delivery of chemotherapy for neoplasm (X72-X73).

See also PCSX2: Intravenous infusions and intravenous injections

From April 2020, with the exception of those codes listed above, the OPCS-4 High Cost Drugs codes are not required for National Cost Collection or the NHS National Tariff Payment System.

The National Tariff High Cost Drugs List and associated High Cost Drugs Clinical Coding Standards and Guidance were withdrawn inApril 2020. The previous National Tariff High Cost Drugs List is available in the resource library on Delen, should Trusts wish to collect this data for local purposes.

Codes from elsewhere within OPCS-4 can be used to capture the method and site of administration of drugs.
For more information on neutralising monoclonal antibodies administered for COVID-19 see *Coronavirus » Interim Clinical Commissioning Policy: Casirivimab and imdevimab for patients hospitalised due to COVID-19 (england.nhs.uk)*

Examples:

Ranibizumab (Lucentis) injection into vitreous body of left eye.

C79.4 Injection into vitreous body NEC
Z94.3 Left sided operation

Injection of Botulinum Toxin (Botox) into sweat glands of right axilla

S53.2 Injection of therapeutic substance into skin
Z49.2 Skin of axilla
Z94.2 Right sided operation

Patient with rheumatoid arthritis admitted solely for intermittent IV infusion of Rituximab

X28.1 Intermittent intravenous infusion of therapeutic substance

See also ***PCSX2: Intravenous infusions and intravenous injections***.

PCSX29: Supportive care therapies related to cancer treatment

Granulocyte-colony stimulating factor (G-CSF) given as supportive care to treat the effects of systemic anti-cancer therapy must only be coded when:

- it is confirmed that the G-CSF is in addition to the chemotherapy regimen itself and is **not a component drug** of the patient's chemotherapy regimen
- and the patient attends **solely for the purpose** of receiving G-CSF.

One of the following two codes must be assigned depending on the method of delivery:

- **X38.7 Subcutaneous injection of haematological growth factor**
- **X29.2 Continuous intravenous infusion of therapeutic substance NEC**

G-CSF given as supportive care to treat the effects of systemic anti-cancer therapy must not be coded when:

- it is confirmed that the G-CSF **is a component drug** of the patient's chemotherapy regimen (as it is included in the OPCS-4 code for the chemotherapy regimen).

When G-CSF is administered or supplied to a patient in the treatment of **non-neoplastic** related neutropenic conditions these are coded using codes **X29.2** (if solely admitted for administration of G-CSF) or **X38.7.**

Zoledronic acid, Pamidronate or Ibandronate are examples of a group of medicines called bisphosphonates and are therefore also supportive care therapies, which are also not included on the Chemotherapy Regimens list. **X29.2 Continuous intravenous infusion of therapeutic substance NEC** must be assigned for day cases and inpatients when the patient has been **admitted solely for the purpose** of an intravenous infusion of Zoledronic acid, Pamidronate or Ibandronate.

See also:

- ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)***
- ***PCSX28: Route of administration of chemotherapy for neoplasm***

One of the main side effects in patients undergoing systemic anti-cancer therapy is a reduction in the number of white blood cells. The reduction in white blood cells reduces the body's ability to fight infection, increasing the likelihood of the patient developing an infection. If an infection develops, then chemotherapy may have to be reduced or delayed, compromising the patient's treatment, which can result in the progression of their condition.

G-CSF therapy is given to patients undergoing chemotherapy for systemic anti-cancer therapy to stimulate the bone marrow to produce white blood cells more quickly, decreasing the risk of the patient developing an infection.

G-CSF therapy is also used in the treatment of patients with non-neoplastic conditions and diseases who have an infection, such as neutropenic patients with sepsis. It may also be administered to patients with non-neoplastic conditions and diseases as a prophylactic measure to reduce the risk of infection, such as in patients with advanced HIV with persistent neutropenia. Another use of G-CSF is to stimulate the production of stem cells before harvesting them for use in peripheral blood stem cell transplants.

Filgrastim, Lenograstim and Pegfilgrastim are examples of different types of G-CSF.

G-CSF therapy is administered via subcutaneous injection or as an intravenous infusion.

Supportive care therapies, such as Bisphosphonates and granulocyte-colony stimulating factor (G-CSF) are only included in the Regimens list where they are included as a standard component of a regimen; for example, the regimen FLAG contains G-CSF as a standard component.

PCSX30: Other chemotherapy drugs (X74)

Codes in category **X74.- Other chemotherapy drugs:**

- Must only be used for the coding of cancer hormonal treatment drugs when directed to by the National Tariff Chemotherapy Regimens List 2017-18.
- Must only be coded once per Hospital Provider Spell, usually on the first consultant episode in which the drug was administered. Codes in category **X74** must **only** be assigned for systemic anti-cancer therapy for the treatment of malignant or in-situ neoplasms. Where a drug that appears on the chemotherapy regimens list is used for the treatment of **non-neoplastic/non-malignant** diseases and conditions, these must not be classified using codes from **X74**, codes from elsewhere within OPCS-4 can be assigned where appropriate.

See also:

- ***PRule 11: National Tariff Chemotherapy Regimens List***
- ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)***

Example:

A patient with advanced prostate cancer is prescribed Abiraterone

X74.1 Cancer hormonal drugs Band 1

PCSX31: Chemo-radiation/chemo-radiotherapy

When coding chemo-radiotherapy both the radiotherapy and chemotherapy elements must be coded by applying ***PCSX20: Radiotherapy (X65, X67–X69)***, ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)*** and ***PCSX28: Route of administration of chemotherapy for neoplasm***.

There are a number of regimens listed that have a component of radiotherapy; these are sometimes referred to as chemo-radiation. These can be given concurrently to the chemotherapy on the same day or at a separate attendance.

There is no national standard for the sequencing of the chemotherapy codes with the radiotherapy codes.

Electrochemotherapy/electroporation (Y12.3)

See PCSY14: Electrochemotherapy/electroporation (Y12.3)

PCSX25: Administration of thrombolytic/fibrinolytic drugs and alteplase/tenecteplase

When a thrombolytic/fibrinolytic drug (with the exception of alteplase and tenecteplase for acute stroke) has been administered they must be coded according to the method of administration.

When alteplase or tenecteplase has been administered in the treatment of acute stroke code **X83.3 Fibrinolytic drugs Band 1** must be assigned. If administered for any other condition, this must be coded according to the method of administration.

This is an exception to **PCSX2: Intravenous infusions and intravenous injections.**

See also PCSX24: High Cost Drugs (X81–X98).

Thrombolytic/fibrinolytic drugs include alteplase, reteplase, streptokinase and tenecteplase.

CHAPTER Y SUBSIDIARY CLASSIFICATION OF METHODS OF OPERATION
(Y01–Y99, O44, O48)

Chapter standards and guidance

Markers are used to identify a lesion for later treatment: these include radioactive and wire markers. Markers may be inserted at the same time as another procedure on a lesion (e.g. a biopsy) or during a separate theatre visit. The marker insertion would be coded in addition to any other diagnostic or therapeutic procedures.

Example:

Insertion of wire marker into carcinoma of left breast under ultrasonic control for later excision

B37.8 Other specified other operations on breast
Y37.3 Insertion of wire marker into organ NOC
Y53.2 Approach to organ under ultrasonic control
Z94.3 Left sided operation

A code(s) from category **Y79 Approach to organ through artery** can be assigned as an additional code(s) with percutaneous transluminal procedure codes in Chapters J, K and L when the artery used for a transluminal approach has been specified in the medical record. Multiple different codes from **Y79** can be assigned if multiple arteries have been used to approach an organ.

See also: PCSY7: Approach to organ under image control (Y53, Y68 and Y78)

Subsidiary Chapters Y and Z

See PRule 7: Subsidiary Chapters Y and Z

Sequencing of codes in Chapter Y with codes in Chapter Z

See PGCS14: Sequencing of codes in Chapter Y with codes in Chapter Z.

PChSY1: Use of codes in Chapter Y

Codes from Chapter Y are used to enhance codes from the body system chapters where this adds further information about the intervention/procedure that cannot be fully reflected by the assignment of the body system code alone. In many cases a note exists at category or subcategory code level within the main body system chapters indicating that a code from Chapter Y is required, however these codes can also be assigned to codes where one of these notes is not present.

Codes in Chapter Y must only be used in a secondary position following a code from the body system chapters (A–X).

Examples:

Laser therapeutic keratectomy right eye

C45.1 Superficial keratectomy
Includes: Laser keratectomy
Note: For laser keratectomy use a subsidiary code to identify laser modification of organ (Y08.5)
Y08.5 Laser modification of organ NOC
Z94.2 Right sided operation

Endoscopic total laser excision of meniscus of right knee

W82.1 Endoscopic total excision of meniscus of knee joint
Y08.1 Laser excision of organ NOC
Z94.2 Right sided operation

Coding standards and guidance

PCSY1: Argon plasma coagulation (Y10.2 and Y17.1)

When coding Argon Plasma Coagulation (APC) codes **Y10.2 Electrocauterisation of organ NOC** or **Y17.1 Electrocauterisation of lesion of organ NOC** must be used in addition to a code that classifies a cauterisation procedure. Where a cauterisation code does not exist, a code for destruction must be used. These codes must **not** be used to classify APC when used as a means of haemostasis at the end of a procedure.

See also PGCS20: Procedures performed for haemostasis

Example:

Fibreoptic endoscopic argon plasma coagulation of lesion of pylorus.

G43.3 Fibreoptic endoscopic cauterisation of lesion of upper gastrointestinal tract
Y17.1 Electrocauterisation of lesion of organ NOC
Z27.3 Pylorus

PCSY14: Electrochemotherapy/electroporation (Y12.3)

Where electrochemotherapy or electroporation is performed following delivery of a chemotherapy regimen this must be coded as follows:

Body system chapter code
Y12.3 Electrochemotherapy to lesion of organ NOC
Includes: Electroporation to lesion of organ NOC
Chapter Z site code(s)
Z94.- Laterality of operation (if applicable)

These codes must be sequenced after the relevant delivery code in categories **X72-X73.**

See:

- ***PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)***
- ***PCSX28: Route of administration of chemotherapy for neoplasm***

Example:

A patient is prescribed cisplatin electrochemotherapy for malignant melanoma of left shoulder.

X72.1 Delivery of complex chemotherapy for neoplasm including prolonged infusional treatment at first attendance
S60.8 Other specified other operation on skin
Y12.3 Electrochemotherapy to lesion of organ NOC
Z49.6 Skin of shoulder
Z94.3 Left sided operation

PCSY13: Insertion and removal of mesh (Y26 and Y28)

Insertion of mesh

When coding procedures where mesh is inserted, one of the following codes must be assigned in addition when the type of mesh used is known:

Y28.1 Insertion of synthetic mesh into organ NOC
Y28.2 Insertion of biological mesh into organ NOC
Y28.3 Insertion of composite mesh into organ NOC

Or when the type of mesh used is not known:

Y28.4 Insertion of mesh into organ NOC

The exceptions to this are:

- When coding procedures where the code description contains ‘mesh’ or ‘tape’ (found in Chapters M, P and Q), **Y28.1**, **Y28.2** and **Y28.3** must be assigned in addition only when the type of mesh used is known and this adds further information, **Y28.4 Insertion of mesh into organ NOC** must not be assigned as this does not add further information.

- Where a sling is inserted and the code description contains ‘sling’ (found in Chapter M), **Y28.1**, **Y28.2**, or **Y28.3** must be assigned in addition only when the sling is made of mesh and the type of mesh used is known; if the sling is made of mesh and the type of mesh used is not known then code **Y28.4 Insertion of mesh into organ NOC** must be assigned in addition.

Removal of mesh

When coding procedures where mesh is removed either **Y26.6 Partial removal of mesh from organ NOC** or **Y26.7 Total removal of mesh from organ NOC** must be assigned in addition, ***except*** when the code description of the removal procedure already contains reference to ‘partial’ or ‘total’ removal of ‘mesh’ or ‘tape’ (found in Chapter M), in which case **Y26.6** or **Y26.7** is not required.

All tapes used in female Pelvic Organ Prolapse (POP) and Stress Urinary Incontinence (SUI) procedures are made of mesh, therefore mesh usage is implicit in codes where the code descriptions states ‘mesh’ or ‘tape’. Slings, however, can either be made of mesh or can be autologous and harvested from the patient’s own body tissue (for example a fascial

sling); it is therefore not implicit in codes where the description contains 'sling' that the sling is made of mesh.

See also Appendix 1: Procedures performed for female pelvic organ prolapse and stress urinary incontinence for a guidance table containing procedures performed for female Stress Urinary Incontinence and Pelvic Organ Prolapse that are not easily reached using the OPCS-4 Alphabetical Index. The table is intended to assist coders in the correct assignment of codes.

Radioactive implants (Y35 and Y36)

For the standards when assigning codes in categories Y35 and Y36 for radiotherapy procedures see PCSX20: Radiotherapy (X65, X67-X69).

PCSY2: Insertion of adhesion barrier (Y36.8)

For procedures that include the insertion of an adhesion barrier that prevent the formation of adhesions following surgery the following code must be assigned in addition to the main procedure code:

Y36.8 Other specified introduction of non-removable material into organ NOC

Fluorescence cystoscopy and cystoscopy using photodynamic substance (Y37.1)

See PCSM5: Fluorescence cystoscopy and cystoscopy using photodynamic substance.

PCSY15: Drug-eluting balloons (Y37.2)

When a drug-eluting balloon is used during an angioplasty and/or insertion of stent procedure, **Y37.2 Introduction of substance into organ using drug-eluting balloon NOC** must be assigned in addition.

Drug-eluting balloons are used to deliver drugs to specific areas within blood vessels and can be inserted following pre-dilation using a non-drug-coated balloon. They can be used

either as part of an angioplasty procedure or in repeat stenting procedures (for example, to treat in-stent stenosis).

PCSY3: Lipofilling (Y39.4)

Code **Y39.4 Lipofilling injection into organ NOC** is to be used as a supplementary code for lipofilling on any area other than the breast.

Example:

Lipofilling of both cheeks. Fat taken from the right inner upper thigh

S62.8 Other specified other operations on subcutaneous tissue
Y39.4 Lipofilling injection into organ NOC
Z47.3 Skin of cheek
Includes: Subcutaneous tissue of face
Z94.1 Bilateral operation
Y67.2 Harvest of composite of skin and fat
Includes: Harvest of dermis fat NEC
Z50.4 Skin of leg NEC
Includes: Subcutaneous tissue of other site
Z94.2 Right sided operation

PCSY4: Endoscopic tattooing of lesions (Y39.5)

If during an endoscopy, lesions are marked by tattooing with ink so that they may be positively identified at a later date, code **Y39.5 Tattooing of organ NOC** must be assigned as a supplementary code.

PCSY5: Endoscopic ultrasound staging examination of organ NOC (Y41.2)

When an endoscopic ultrasound examination (EUS) is performed as a staging examination code **Y41.2 Endoscopic ultrasound staging examination of organ NOC** must be assigned in addition to the body system EUS code.

PCSY6: Approach to organ (Y45–Y52 and Y74-Y77)

Where a method of approach classifiable to categories **Y45–Y52 and Y74-Y77** is not incorporated within the body system code description, a code from categories **Y45–Y52 and Y74-Y77** must be assigned directly after the body system code to identify the method of approach. Any site and laterality codes must be assigned after the approach code. Where a number of procedures have taken place using different methods of approach a code from categories **(Y45–Y52 and Y74-Y77)** must be assigned after each body system code.

See also:

- ***PGCS1: Endoscopic and minimal access operations that do not have a specific code***
- ***PChSK1: Percutaneous transluminal operations that do not have a specific code***

The classification recognises the resource differences between alternative methods of approach to certain operations, particularly open and endoscopic procedures.

In many cases, the method of approach is incorporated into the code itself, e.g. **J36.1 Excision of ampulla of Vater using duodenal approach**.

Examples:

Open biopsy of lesion of frontal region of brain through frontal burrhole

A04.1 Open biopsy of lesion of tissue of frontal lobe of brain
Y47.2 Frontal burrhole approach to contents of cranium

Thoracoscopic video-assisted biopsy of lesion of lung

E59.3 Biopsy of lesion of lung NEC
Y74.4 Thoracoscopic video-assisted approach to thoracic cavity

FESS repair of sphenoid sinus

E15.3 Repair of sphenoidal sinus
Y76.1 Functional endoscopic sinus surgery

PCSY7: Approach to organ under image control (Y53, Y68 and Y78)

The following applies to codes in categories **Y53 Approach to organ under image control, Y68 Other approach to organ under image control** and **Y78 Arteriotomy approach to organ under image control:**

- When a procedure has been performed using image control and the code that classifies the procedure ***does not*** state the type of image control used, then a code from these categories ***must be*** assigned. If the specific method of image control is not stated, the fourth-character **.9** must be assigned
- The code(s) from categories **Y53, Y68** or **Y78** must be sequenced after the intervention and before the site and laterality codes
- If the code that classifies the procedure states the type of image control used, a code from categories **Y53, Y68** or **Y78** ***must not*** be assigned. e.g. **L72.6 Intravascular ultrasound of artery NEC** and **Q51.1 Transvaginal ultrasound guided aspiration of ovarian cyst**
- If the type of image control used is implicit in the procedure, i.e. the procedure is always carried out using one specific form of image control, then a code from categories **Y53, Y68** and **Y78** ***must not*** be assigned: e.g. **R37.3 Fetal biometry** which is always carried out using ultrasound.
- If image control has been used before, during or after a procedure as a method of checking the anatomical position, or the position of a prosthesis/fixator after insertion, or to confirm a procedure is complete, a code to classify the image control ***must not*** be assigned.

Y53 Approach to organ under image control and Y68 Other approach to organ under image control

Codes in category **Y53 Approach to organ under image control** and **Y68 Other approach to organ under image control** are used as additional codes for any procedure that uses image control that may or may not be performed via percutaneous approach. This excludes those procedures performed using an arteriotomy approach under image control (**Y78**).

- Where a number of different types of image control have been used together a code for each type of image control used must be assigned. The exception to this is fluoroscopy when used with an image intensifier, where it is only necessary to assign code **Y53.4 Approach to organ under fluoroscopic control**.

See also:

- ***PCSY11: Gestational age (Y95)***
- ***Chapter Y for guidance on the use of codes in category Y79 Approach to organ through artery to specify the artery used for transluminal approaches***

Y78 Arteriotomy approach to organ under image control

Codes within category **Y78 Arteriotomy approach to organ under image control** must only be used where it is clear that an arteriotomy approach using image control has been performed. Common terms which indicate an arteriotomy has been performed are: incision into artery, surgical cut-down or cutting of artery.

The arteriotomy will always require closure with either suture or clips to the overlying skin and this must not be coded in addition.

The majority of interventions that are undertaken on arteries by radiologists and some surgeons are referred to as Interventional Radiology procedures and are minimally invasive. These are usually undertaken by putting local anaesthetic in the skin and then passing a small needle and tube into the artery without a surgical incision. This is referred to as a percutaneous access and the intervention is classed as a 'percutaneous transluminal' procedure.

Once inside the artery, the radiologist or surgeon needs a means of visualising the artery and this is achieved by using image control.

An arteriotomy is a method of approach used to gain access to the inside of the artery by surgical incision. Most patients having an arteriotomy will have a treatment that does not require image guidance as the surgeon will have a direct view of the artery. However, some interventions, in particular stent grafts for aneurysms, require incision away from the site of the procedure, and therefore require some form of image control to allow precise visualisation.

Examples:

Percutaneous transluminal ablation of ventricular wall under image control

K57.6 Percutaneous transluminal ablation of ventricular wall
Y53.9 Unspecified approach to organ under image control

Percutaneous biopsy of lesion of liver under x-ray (radiological) control

J13.2 Percutaneous biopsy of lesion of liver NEC
Y53.1 Approach to organ under radiological control

Percutaneous transluminal insertion of one plastic stent into left femoral artery under image control

L63.5 Percutaneous transluminal insertion of stent into femoral artery
Note: Use a supplementary code for placement of stent (L76, L89, O20)
L76.2 Endovascular placement of one plastic stent
Y53.9 Unspecified approach to organ under image control
Z94.3 Left sided operation

Manipulation of fractured right radius under image intensifier

W26.2 Manipulation of fracture of bone NEC
Y53.5 Approach to organ under image intensifier
Z70.9 Radius NEC
Z94.2 Right sided operation

Insertion of one endovascular stent graft into infrarenal abdominal aortic aneurysm using fluoroscopic guidance via femoral artery incision

L27.1 Endovascular insertion of stent graft for infrarenal abdominal aortic aneurysm
O20.3 Endovascular placement of one stent graft NEC
Y78.1 Arteriotomy approach to organ using image guidance with fluoroscopy

Insertion of nasogastric feeding tube into stomach; tube position checked with ultrasound to ensure correct siting

G47.5 Insertion of nasogastric tube

Open reduction of fragment of right scaphoid and screw fixation. The position of the screw was checked using image intensifier

W19.5 Primary open reduction of fragment of bone and fixation using screw
Z72.2 Scaphoid bone
Z94.2 Right sided operation

L4/L5 posterior decompression for spinal stenosis, level checked with x-ray prior to incision

V25.5 Primary posterior decompression of lumbar spine
V55.1 One level of spine

Coding grafts, harvests and donations

See:

- ***PGCS12: Coding grafts and harvests of sites other than skin***
- ***PCSS3: Coding skin grafts and harvests***
- ***PCSX12: Donation of skin (X46.2)***
- ***PCSW14: Implantation of stem cells into joint***
- ***PCSY12: Donor status (Y99)***.

Maintenance and attention to procedures

See PGCS17: Maintenance and attention to procedures.

Staged procedures (Y70.3, Y71.1 and Y71.7)

See PGCS18: Staged procedures.

Temporary operations

See PGCS19: Temporary operations.

Failed minimal access and percutaneous transluminal procedures converted to open (Y71.4, Y71.5, Y72.1 and Y72.2)

See ***PGCS4: Failed minimal access and percutaneous transluminal procedures converted to open (Y71.4, Y71.5, Y72.1 and Y72.2)***.

Endoscopic and minimal access operations that do not have a specific code (Y74-Y77)

See PGCS1: Endoscopic and minimal access operations that do not have a specific code.

PCSY8: Cardiopulmonary bypass and modified ultrafiltration adjunct to cardiopulmonary bypass (Y73.1 and Y73.4)

Y73.1 Cardiopulmonary bypass or **Y73.4 Modified ultrafiltration adjunct to cardiopulmonary bypass** must always be assigned in a secondary position whenever it is stated that either has been carried out.

When modified ultrafiltration and cardiopulmonary bypass are performed at the same time, only code **Y73.4** is required, as cardiopulmonary bypass is implicit within code **Y73.4**.

PCSY9: Intraoperative fluid monitoring (Y73.6)

Y73.6 Intraoperative fluid monitoring which includes Oesophageal Doppler Monitoring (ODM) must only be coded once per theatre visit.

PCSY10: Anaesthetic (Y80-Y84)

When radiotherapy is delivered under general anaesthetic, a code from category **Y80 General anaesthetic** must be assigned in addition to the radiotherapy codes, ***see PCSX20: Radiotherapy (X65, X67–X69).***

See also PCSX17: Anaesthetic without surgery (X59).

In all other cases anaesthetics may be recorded if this information is required to be collected locally.

It is regarded as best practice to record epidurals or spinals performed on obstetric patients.

Brachytherapy (Y89), External beam radiotherapy (Y91 and O44) and support for preparation for radiotherapy (Y92)

For the standards when assigning codes in categories Y89, Y91, Y92 and O44 for radiotherapy procedures see PCSX20: Radiotherapy (X65, X67-X69).

Gallium-67 imaging (Y93) and Radiopharmaceutical imaging (Y94)

For the standards when assigning codes in categories Y93 or Y94 for nuclear medicine procedures see PCSU3: Nuclear medicine imaging procedures.

PCSY11: Gestational age (Y95)

Where information is available about the gestation of the pregnancy, codes in category **Y95 Gestational age** must be assigned in a subsidiary position to the code describing the procedure related to the pregnancy where there is a ***Note*** at category and code level.

Where a code from categories **Y95** and **Y53** or **Y68** are both required the code from category **Y53** or **Y68** must be sequenced before the code from **Y95**.

See also ***PChSY1: Use of codes in Chapter Y***

A use subsidiary code note exists at certain codes in Chapters Q and R but **Y95** can also be assigned in addition to codes where this note is not present, including codes in other Chapters where appropriate.

Example:

Percutaneous blood transfusion of 22 week fetus under ultrasonic control

R04.3 Percutaneous blood transfusion of fetus
Note: Use a subsidiary code to identify method of image control (Y53)
Note: Use a subsidiary code to identify gestational age (Y95)
Y53.2 Approach to organ under ultrasonic control
Y95.1 Over twenty weeks gestational age

In vitro fertilisation (Y96)

See PCSQ3: In vitro fertilisation (Q13.1, Q21.1 and Q38.3).

Radiological contrast and body areas (Y97-Y98)

See PCSU2: Radiological contrast and body areas (Y97-Y98).

PCSY12: Donor status (Y99)

Codes within category **Y99 Donor status** must only be assigned in addition to the OPCS-4 code which describes the transplantation procedure where they provide additional information that is not stated in the main operation code.

Codes from **Y99** must only be assigned on the recipient's hospital episode and not the donor's episode.

See:

- ***PGCS12: Coding grafts and harvests of sites other than skin***
- ***PCSX8: Bone marrow transplantation and peripheral stem cell transplantation.***

Example:

Allotransplantion of right kidney from patient's sister

M01.2 Allotransplantation of kidney from live donor
Y99.2 Live related donor
Z94.2 Right sided operation

CHAPTER Z SUBSIDIARY CLASSIFICATION OF SITES OF OPERATION

(Z01–Z99, O11–O14, O16, O28, O30-O31, O33-O34, O36, O42-O43, O45-O47, O50, O52-O53)

Chapter standards and guidance

Subsidiary Chapters Y and Z

See PRule 7: Subsidiary Chapters Y and Z

PChSZ1: Use of codes in Chapter Z

Codes from Chapter Z must be used to enhance codes from Chapters A–X where this adds further information about the site and laterality of intervention.

Codes in Chapter Z must only be used in a secondary position following a code from Chapters A–X.

Assigning site codes for endoscopic procedures

See PGCS10: Coding endoscopic procedures for standards for the assignment of site codes when coding endoscopic procedures.

Sequencing of codes in Chapter Y with codes in Chapter Z

See PGCS14: Sequencing of codes in Chapter Y with codes in Chapter Z.

Coding standards and guidance

PCSZ1: Site codes

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

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

For instance where the site of the intervention is already specified within the procedure code description (e.g. **W48.1 Primary prosthetic replacement of head of femur NEC**), or where a site code is not available which further specifies the site or sub site.

See also PChSL2: Assigning codes for specifically classifiable arteries.

Examples:

Repair of right abducens nerve (upper cranial nerve vi)

A30.2 Repair of oculomotor nerve (iii)
Includes: Repair of trochlear nerve (iv)
Repair of abducens nerve (vi)
Z03.6 Abducens nerve (vi)
Z94.2 Right sided operation

Excision of lesion of upper outer quadrant of right breast

B28.3 Excision of lesion of breast
Z15.2 Upper outer quadrant of breast
Z94.2 Right sided operation

Curettage of lesion of skin of forehead

S08.3 Curettage of lesion of skin of head or neck NEC
Z47.1 Skin of forehead

Open reduction and internal fixation (ORIF) of fractured left distal radius using plate

W20.1 Primary open reduction of fracture of long bone and extramedullary fixation using plate NEC
Z70.5 Lower end of radius NEC
Z94.3 Left sided operation

PCSZ2: Laterality of operation (Z94)
When laterality is documented in the medical record, and is not already implicit in the code description, it must be coded. Chapter K Heart is the exception to this standard. **Z94 Laterality of operation** must not be assigned in addition to procedures in Chapter K. ***See also PChSK2: Coding laterality on procedures in chapter K***
When multiple procedures are carried out on the same site it is only necessary to assign the laterality code once after all of the procedures on that site. However, there is nothing to prohibit the assignment of the laterality code multiple times in such instances, if a Trust has a local need to do so. Within Chapter K Heart, where laterality is significant to the procedure, it is already included in the code title.

Examples:

Bilateral dissection tonsillectomy

F34.1 Bilateral dissection tonsillectomy

Endoscopic cryoablation of lesion of right kidney, patient previously had their left kidney removed 3 years ago.

M10.4 Endoscopic cryoablation of lesion of kidney
Z94.2 Right sided operation

Arthroscopic acromioplasty with excision (decompression) of arthritic AC joint right shoulder

O29.1 Subacromial decompression
Y76.7 Arthroscopic approach to joint
W84.4 Endoscopic decompression of joint
Z81.2 Acromioclavicular joint
Z94.2 Right sided operation

Curettage of lesion of right cheek, shave excision of lesion from left external ear and cauterisation of lesion of skin of right buttock

S08.3 Curettage of lesion of skin of head or neck NEC
Z47.3 Skin of cheek
Z94.2 Right sided operation
D02.1 Excision of lesion of external ear
S06.3 Shave excision of lesion of skin of head or neck
Z94.3 Left sided operation
S11.1 Cauterisation of lesion of skin NEC
Z49.5 Skin of buttock
Z94.2 Right sided operation

Primary suture of laceration of skin on the left side of the back

S42.1 Primary suture of skin NEC
Z49.4 Skin of back
Z94.3 Left sided operation

Cauterisation of basal cell carcinoma (BCC) from the skin of the left and right arms

S11.1 Cauterisation of lesion of skin NEC
Z50.1 Skin of arm
Z94.1 Bilateral operation

APPENDICES

Appendix 1: Procedures performed for pelvic organ prolapse and stress urinary incontinence

The guidance table below contains procedures performed for Stress Urinary Incontinence (SUI) and Pelvic Organ Prolapse (POP) and is included to assist coders in the correct assignment of codes.

***Paused Procedures (denoted by red text within the table)**

The use of the following procedures has been paused as a result of recommendations made by the Independent Medicines and Medical Devices Safety Review:

M53.3 Introduction of tension-free vaginal tape
M53.6 Introduction of transobturator tape
M57.1 Introduction of vaginal tape NEC
P23.6 Anterior colporrhaphy with mesh reinforcement
P23.7 Posterior colporrhaphy with mesh reinforcement
P24.6 Repair of vault of vagina with mesh using vaginal approach
Q54.6 Infracoccygeal hysteropexy

Paused procedures may still be performed in exceptional circumstances when there is no viable alternative, and following close and comprehensive consultation between patient and clinician.

Before assigning any of the paused procedure codes listed above, coders are advised to check with the responsible consultant to ensure the procedure has definitely been performed. See Pause on the use of vaginally inserted surgical mesh for stress urinary incontinence. - GOV.UK (www.gov.uk) for more information.

Coders must apply caution when assigning codes included in the table below and must ensure that the codes assigned reflect the actual procedure documented within the medical record; therefore, in some cases the correct code assignment may differ from those presented in the table.

This guidance was produced in collaboration with clinical representatives of the NHS England Mesh Registry sub-group.

See also:

- ***PRule8: Surgical eponyms***
- ***PGCS1: Endoscopic and minimal access operations that do not have a specific code***
- ***PGCS12: Coding grafts and harvests of sites other than skin***
- ***PCSM11: Tape removal procedures (M53 and M57)***
- ***PCSY6: Approach to organ (Y45–Y52 and Y74-Y76)***

- ***PCSY13: Insertion and removal of mesh (Y26 and Y28)***.

Procedures for Stress Urinary Incontinence (SUI)		
Sex	**Procedure**	**Procedure code(s)**
Female	Colposuspension *May also be described as:* • *Bladder neck suspension* • *Burch colposuspension* • *Burch procedure*	Open
		M52.3
		Laparoscopic
		M52.3 **Y75.-**
Both	Injection, Botox (intravesical)	**M43.4**
Female	Insertion, retropubic tape *May also be described as insertion of:* • *RP tape* • *Tension free vaginal tape* • *TVT* • *Retropubic tension free vaginal tape* • *Synthetic mid-urethral sling* **Paused procedure – see introduction to this guidance*	**M53.3*** **Y28.1-Y28.3** (if the type of mesh tape used is known)
Female	Insertion: • Single incision tape • Single incision mini-sling • Single incision short mesh sling **Paused procedure – see introduction to this guidance*	**M57.1*** **Y28.1-Y28.3** (if the type of mesh tape used is known)

Female	Insertion, transobturator mesh tape *May also be described as insertion of:* • *TOT* • *TVTO* • *Transobturator tension free vaginal tape* • *Transobturator synthetic mid-urethral sling* **Paused procedure – see introduction to this guidance*	**M53.6*** **Y28.1-Y28.3** (if the type of mesh tape used is known)
Male	Insertion, transobturator mesh tape *May also be described as:* • *Transobturator sling* • *TOT* • *Transobturator synthetic mid-urethral sling*	**M64.7** **Y28.1-Y28.4**
Female	Sling, fascial - Aldridge sling *May also be described as (with fascia harvested from the abdominal wall):* • *Traditional retropubic sling* • *Autologous fascial sling* • *Native tissue sling* • *Autologous Supra-pubic sling*	**M51.3** **Y60.3**
Female	Sling, fascial - Sling on a string *May also be described as:* • *Traditional retropubic sling* • *Autologous fascial sling* • *Native tissue sling* • *Autologous Supra-pubic sling*	**M51.3** **Y60.-**
Female	Supra-pubic sling NEC	**M52.1** **Y50.3** **Y60.-**

Procedures for Pelvic Organ Prolapse (POP)		
Male or Female	**Procedure**	**Procedure code(s)**
Female	Cervicopexy, sacrospinous	**Q57.2** **Y50.3**
Female	Colpopexy, infracoccygeal *May also be described as Infracoccygeal vault mesh suspension* **Paused procedure – see introduction to this guidance*	**P24.6*** **Y28.1-Y28.4**
Female	Colpopexy, sacrospinous	**P24.7**
Female	Fixation, iliococcygeal	**P24.7**
Female	Fixation, sacrospinous, uterus using mesh **Paused procedure – see introduction to this guidance*	**Q57.2*** **Y50.3** **Y28.1-Y28.4**
Female	Hysteropexy *May also be described as:* • *Sacrohysteropexy* • *Sacrocervicopexy* • *Sacrocolpohysteropexy*	Open
		Q54.5 **Y28.1-Y28.4** (if mesh is used)
		Laparoscopic
		Q54.5 **Y75.-** **Y28.1-Y28.4** (if mesh is used)
Female	Hysteropexy, laparoscopic suture	**Q54.5** **Y75.-**
Female	Hysteropexy, sacrospinous	**Q57.2** **Y50.3**

Female	Plication, uterosacral (ligament)	Open
		Q57.4
		Laparoscopic approach
		Q57.4 **Y75.-**
Female	McCall Culdoplasty	Open
		P31.1
		Laparoscopic approach
		P31.1 **Y75.-**
Female	Repair, vagina anterior *May also be described as:* • *Anterior colporrhaphy* • *Cystocele repair* **Paused procedure – see introduction to this guidance*	**P23.2**
		With mesh reinforcement/ using mesh
		P23.6* **Y28.1-Y28.3** (if the type of mesh tape used is known)
		With Manchester repair/ amputation of cervix uteri
		P22.2
Female	Repair, vagina posterior *May also be described as:* • *Posterior colporrhaphy* • *Rectocele repair* **Paused procedure – see introduction to this guidance*	**P23.3**
		With mesh reinforcement/ using mesh
		P23.7* **Y28.1-Y28.3** (if the type of mesh tape used is known)
		With Manchester repair/ amputation of cervix uteri

		P22.3
Female	Repair, vagina anterior and posterior *May also be described as:* • *Anterior and posterior colporrhaphy* • *Cystocele and rectocele repair*	**P23.1**
		With Manchester repair/ amputation of cervix uteri
		P22.1
Female	Repair, Manchester *May also be described as amputation of cervix uteri* *Excludes when performed with Anterior and/or posterior colporrhaphy –* ***P22.1-P22.3***	**Q01.1**
Female	Repair, rectoenterocele	**P23.4**
Female	Sacrocolpocervicopexy	Open
		P24.2 **Y28.1-Y28.4** (if mesh is used)
		Laparoscopic approach
		P24.2 **Y75.-** **Y28.1-Y28.4** (if mesh is used)
Female	Sacrocolpohysteropexy	Open
		Q54.5 **Y28.1-Y28.4** (if mesh is used)
		Laparoscopic approach
		Q54.5 **Y75.-** **Y28.1-Y28.4** (if mesh is used)
Female	Slingplasty, posterior intravaginal	**Q54.6***

	**Paused procedure – see introduction to this guidance*	**Y28.1-Y28.4** (if mesh is used)
Female	Suspension, mesh, infracoccygeal, uterine **Paused procedure – see introduction to this guidance*	**Q54.6*** **Y28.1-Y28.4**

Procedures for Rectal Prolapse (both male and female)	
Procedure	**Procedure code(s)**
Rectopexy, abdominal posterior resection	Without mesh
	H35.3 **H10.-** (if the sigmoid is resected)
	With mesh
	H35.2 **Y28.1-Y28.4** **H10.-** (if the sigmoid is resected)
Rectopexy, ventral mesh *May also be described as:* • *Anterior rectopexy with mesh* • *VMR*	Open
	H35.5 **Y28.1-Y28.4**
	Laparoscopic
	H35.5 **Y75.-** **Y28.1-Y28.4**
Altemeier procedure	**H33.7**
Delorme procedure	**H42.5** or **H33.7** or **H42.6** or **H42.8**

Removal of tapes inserted for SUI			
Male or Female	**Procedure**		**Procedure code(s)**
Female	Removal, endoscopic/cystoscopic transurethral, mesh erosion from urethra or bladder: • Retropubic tape • RP tape • Tension free vaginal tape • TVT • Transobturator tape • TOT		Urethra
			M78.1 **Y26.6 or Y26.7**
			Bladder
			M44.5 **Y26.6 or Y26.7**
Female	Removal, retropubic tape *May also be described as removal of:* • *RP tape* • *Tension free vaginal tape* • *TVT* • *Retropubic tension free vaginal tape* • *Synthetic mid-urethral sling*	Total	Combined vaginal and laparoscopic approach
			M53.4 **Y50.3** **Y75.-**
			Combined vaginal and abdominal (open) approach
			M53.4 **Y50.3** **Y50.2**
		Partial - *may involve removing vaginal, abdominal or subcuticular portions of the tape.*	Laparoscopic approach
			M53.5 **Y75.-**
			Vaginal approach
			M53.5 **Y50.3**

			Abdominal (open) approach
			M53.5 **Y50.2**
Female	Removal: • Single incision tape • Single incision mini-sling • Single incision short mesh sling	Total	Vaginal approach
			M57.2 **Y50.3**
			Combined vaginal and groin incision/dissection approach
			M57.2 **Y50.3** **Y77.2**
		Partial - *may include the removal of hooks or anchors.*	Vaginal approach
			M57.3 **Y50.3**
			Groin incision/dissection approach
			M57.3 **Y77.2**
Female	Removal, transobturator mesh tape *May also be described as removal of:* • *TOT* • *TVTO* • *transobturator tension free vaginal tape*	Total	Combined vaginal and groin incision/dissection approach
			M53.7 **Y50.3** **Y77.2**
			Combined abdominal (open), vaginal and groin incision/dissection approach

			M53.7 **Y50.2** **Y50.3** **Y77.2**
			Combined laparoscopic, vaginal and groin incision/dissection approach
			M53.7 **Y75.-** **Y50.3** **Y77.2**
		Partial - may involve removing vaginal, abdominal or subcuticular portions of the tape.	Vaginal approach
			M57.4 **Y50.3**
			Groin incision/dissection approach
			M57.4 **Y77.2**
Male	Removal, transobturator mesh tape *May also be described as:* • *TOT (mesh)* • *Transobturator synthetic sling (mesh)*	Total	Open approach
			M60.5 **Y26.7**
			Laparoscopic approach
			M60.5 **Y75.-** **Y26.7**
		Partial	**M60.6** **Y26.6**
Removal of mesh inserted for POP			

Male or Female	Procedure		Procedure code(s)
Female	Removal, mesh implanted during previous repair of uterine prolapse	Total	Laparoscopic approach
			Q54.7 **Y75.-** **Y26.7**
			Vaginal approach
			Q54.7 **Y50.3** **Y26.7**
		Partial	Laparoscopic approach
			Q57.1 **Y75.-** **Y26.6**
			Vaginal approach
			Q57.1 **Y50.3** **Y26.6**
Female	Removal, mesh inserted during previous repair of vaginal prolapse	Total	Vaginal and groin incision/dissection approach
			P28.1 **Y50.3** **Y77.2** **Y26.7**
			Vaginal approach
			P28.1 **Y50.3** **Y26.7**
		Partial	Vaginal and groin incision/dissection approach

			P28.2 **Y50.3** **Y77.2** **Y26.6**
			Vaginal approach
			P28.2 **Y50.3** **Y26.6**
Female	Removal, mesh implanted during previous repair of vaginal vault prolapse	Total	Laparoscopic approach
			P30.1 **Y75.-** **Y26.7**
			Vaginal approach
			P30.1 **Y50.3** **Y26.7**
		Partial	Laparoscopic approach
			P30.2 **Y75.-** **Y26.6**
			Vaginal approach
			P30.2 **Y50.3** **Y26.6**
Other procedures for POP and SUI procedure complications			
Female	Dissection, buttock *Code in addition when performed with removal of mesh*		**T83.4** **Z90.1**

Female	Division, suburethral tape NEC		**M57.7**
Female	Division, tension-free vaginal tape		**M57.5**
Female	Division, transobturator tape		**M57.6**
Female	Martius fat graft		Code describing the structure that is being repaired **Y67.2** **Z44.7**
Female	Oversewing, exposed or eroded vaginal mesh tape		**P29.6**
Female	Plication, mesh	Inserted during previous sacrocolpopexy	Open
			P30.3
			Laparoscopic approach
			P30.3 **Y75.-**
		Inserted during previous sacrohysteropexy or sacrocervicopexy	Open
			Q57.3
			Laparoscopic approach
			Q57.3 **Y75.-**
Other procedures – Miscellaneous			
Female	Excision, diverticulum of urethra		Open
			M72.3
			Vaginal approach
			M72.3

		Y50.3

INDEX OF STANDARDS

SUMMARY OF CHANGES

This section provides notification of all changes to the National Clinical Coding Standards OPCS-4, for use from 1 January 2025.

Each entry is shown with tracked changes to indicate what has changed. Deletions appear as strikethrough in red font while additions appear underlined in blue font. Where part of a standard or guidance has been updated, the whole standard or guidance will be displayed. Where examples are updated, only the example that has been updated will be displayed.

Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated or deleted.

Changes between National Clinical Coding Standards OPCS-4 version 11.1 (April 2024) to 11.2 (January 2025).

CHAPTER X MISCELLANEOUS OPERATIONS (X01–X98)

PCSX25: Administration of thrombolytic/fibrinolytic drugs and alteplase/tenecteplase
When a thrombolytic/fibrinolytic drug (with the exception of alteplase and tenecteplase for acute stroke) has been administered they must be coded according to the method of administration. When alteplase or tenecteplase has been administered in the treatment of acute stroke code **X83.3 Fibrinolytic drugs Band 1** must be assigned. If administered for any other condition, this must be coded according to the method of administration. This is an exception to **PCSX2: Intravenous infusions and intravenous injections.** ***See also PCSX24: High Cost Drugs (X81–X98).***
Thrombolytic/fibrinolytic drugs include alteplase, reteplase, streptokinase and tenecteplase.

SUMMARY OF CHANGES

This section provides notification of all changes to the National Clinical Coding Standards OPCS-4, for use from 1 April 2024.

Each entry is shown with track changes to indicate what has changed. Deletions appear as strikethrough in red font while additions appear underlined in blue font. Where part of a standard or guidance has been updated, the whole standard or guidance will be displayed. Where examples are updated, only the example that has been updated will be displayed.

Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated or deleted.

Changes between National Clinical Coding Standards OPCS-4 version 11.0 (April 2024) to 11.1 (April 2024).

CHAPTER S SKIN
(S01–S70)

Chapter standards and guidance

PChSS2: Coding skin flaps and harvests

Examples:

Local flap of skin of nose from right cheek (responsible consultant confirmed the flap was a random pattern pedicle flap)

E66.1 Flap of skin to external nose
S26.3 Random pattern local subcutaneous pedicle flap of skin to head or neck
~~**Y56.1 Harvest of random pattern flap of skin from head**~~
~~**Z47.3 Skin of cheek**~~
Z94.2 Right sided operation

Excision of lesion of skin of external nose, repaired with a local flap

E09.1 Excision of lesion of external nose
E66.1 Flap of skin to external nose
S27.5 Local flap of skin to head or neck NEC

SUMMARY OF CHANGES

This section provides notification of all changes to the National Clinical Coding Standards OPCS-4, for use from 1 April 2024.

Each entry is shown with track changes to indicate what has changed. Deletions appear as strikethrough in red font while additions appear underlined in blue font. Where part of a standard or guidance has been updated, the whole standard or guidance will be displayed. Where examples are updated, only the example that has been updated will be displayed.

Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated or deleted.

Changes between National Clinical Coding Standards OPCS-4 version 10.2 (April 2023) to 11.0 (April 2024).

INTRODUCTION

~~These national clinical coding standards are for use with the~~ The UK OPCS Classification of Interventions and Procedures (OPCS-4) was developed for use in the collection of intervention and surgical procedure information. The purpose of OPCS-4 is to permit the systematic recording, analysis, interpretation and comparison of surgical procedure and intervention data collected in the NHS. OPCS-4 is used to translate surgical procedures and interventions from words into alphanumeric codes, which permits easy storage, retrieval and analysis of data. The classification ~~when translating~~comprises two volumes:

- Volume 1: Tabular List: includes classification codes and titles at three- and four-character levels, historical background and information about OPCS-4
- Volume 2: Alphabetical Index: includes index terms for interventions and surgical procedures ~~recorded~~, surgical eponyms, abbreviations and surgical suffixes.

The *National Clinical Coding Standards for OPCS-4* are to be used with the two volumes of OPCS-4. They reinforce the classification rules and coding conventions inherent in the OPCS-4 Volumes 1 and 2, give specific instructions for procedure coding including for those areas of potential ambiguity (as far as practically possible) or where data analysis or user feedback requires additional information to safeguard data consistency and comparability. They also include instruction that cannot be embedded into the classification.

Compliance with OPCS-4 and these coding standards enables consistent, accurate and uniform coding which in turn supports the collection and comparison of local and national data across time.

The content type and level of detail within this publication is primarily aimed at a ~~patient's~~clinical coding professional and therefore presumes the user:

Understands the use of the OPCS-4 classification

Is trained in the abstraction of relevant information from the medical record ~~for morbidity coding~~

Possesses knowledge of anatomy and physiology

And for coding purposes, are aware of the methods and processes used when a procedure/intervention is performed on a patient.

The *National Clinical Coding Standards OPCS-4* are the definitive source of clinical coding standards for use in the NHS in England.

These clinical coding standards are also used in Northern Ireland and Wales, with some local variance. For information on specific use of the OPCS-4 classification, clinical coding standards, data definitions and collections in Northern Ireland, Wales and Scotland contact the respective national centre:

- Northern Ireland – Digital Health & Care Northern Ireland – About DHCNI Data
- Wales – Digital Health and Care Wales Information Design and Standards Development
- Scotland – Terminology Services and clinical coding - Services - Public Health Scotland

The NHS Classifications Browser provides a way to browse and search the OPCS-4 classification online. It is regularly updated to reflect changes to the OPCS-4 classification and National Clinical Coding Standards to support consistent application of the classification codes by clinical coders. It is freely available online to anyone with an internet connection.

Background

~~The OPCS Classification of Interventions and Procedures (OPCS-4)~~The OPCS-4 is a statistical classification of interventions and surgical procedures undertaken in the National Health Service (NHS) reflecting current clinical practice. ~~OPCS-4 is an approved NHS Fundamental Information Standard, see http://www.digital.nhs.uk/isce/publication/dcb0084.~~

~~The use of OPCS-4 assumes that:~~

- ~~A patient health record (a medico-legal document) exists, and therefore it is meaningful to have codes that depend on what activity has been specified in that record.~~
- ~~The record is translated and coded, applying the rules, conventions and national standards of the classification, by appropriately trained and qualified clinical coding staff.~~
- ~~Existing data flows are also in place so that when the record is translated and coded, the data can flow from hospital Patient Administration Systems (PAS) and onwards to~~

~~support local and national data requirements through the Secondary Uses Services (SUS).~~

~~The classification is mandatory for use by Health Care Providers to support various forms of data collections, such as Central Returns and Commissioning Data Sets (CDS). All Care Professional Admitted Care Episodes containing procedures must be recorded and collected using OPCS-4. The requirements for data sets and related definitions are specified in the NHS Data Model and Data Dictionary.~~

~~The statistical classification also~~OPCS-4 supports various forms of secondary uses of information essential for planning and improving patient care. ~~-~~Among these secondary uses are:

- Operational and strategic planning,
- Resource use,
- National and local planning and performance management,
- Research and epidemiology,
- Department of Health initiatives, and
- NHS payment system.

~~OPCS-4 is used by NHS suppliers to build or update software to support NHS business functions and interoperability.~~

In England the classification of surgical procedures and interventions using OPCS-4 is a mandatory national requirement for the NHS Admitted Patient Care (APC) Commissioning Data Set (which includes day cases) and other data sets. The requirements for data sets and related definitions are specified in the NHS Data Model and Dictionary.

In England OPCS-4 is an approved Information Standard published under Section 250 of the Health and Social Care Act 2012, see DAPB0084: OPCS Classification of Interventions and Procedures.

Where errors have been identified in the printed OPCS-4 books following publication these will be notified in the ***ICD-10 and OPCS-4 Classifications Content Changes*** document.

~~For information on the use of the OPCS-4 Classification and Clinical Coding Standards used in Northern Ireland, Scotland and Wales contact the respective national centre:~~

- ~~Northern Ireland - Clinical Coding Sharing platform (only available to NI Clinical Coders)~~
- ~~Scotland – Public Health Scotland Terminology Services~~

History of the development of OPCS-4

- ~~Wales – Digital Health and Care Wales Information Design and Standards Development~~

~~Background~~

A statistical classification of surgical operations has been available for use in the United Kingdom (UK) since 1944 when the Medical Research Council published one which identified 442 categories of operation. The then General Register Office prepared and issued an updated version in 1950, and revisions to this were subsequently issued in 1956, (first revision), 1969 (second revision) and 1975 (third revision).

This first classification contained 664 un-subdivided three-character categories. It was revised in 1956 with the addition of 10 categories, and again in 1969 at which time the three-character categories were increased to 731. Some of these categories were subdivided (extended to four-character subcategories) so that the classification contained 1183 valid codes. The third revision, in 1975, further expanded the classification to 1426 valid codes.

The fourth revision of the OPCS-4 was conceived in 1983 as a result of one of the recommendations in the first report in 1982 of the Steering Group on Health Services Information (SGHSI), chaired by Mrs E Korner.

The SGHSI recommended that, “as a matter of urgency, OPCS should provide operation codes, which reflect current clinical practice and develop procedures for the frequent updating of the classification”.

The fourth revision of OPCS was initially issued in 1987 with definitive publication and implementation in 1990. The general objectives of the revision process, which began in 1983, were:

1. To identify and classify current surgical operations with particular reference to the incorporation of recent innovative techniques.
2. To eliminate rarely performed operations but to include procedures not requiring the full operating theatre environment.
3. To provide a flexible classification, responsive to less defined specialty boundaries and capable of future expansion.

Both the Tabular List and Alphabetical Index were updated in January 1990 and the Alphabetical Index was again revised in April 1993. OPCS-4 then contained 1183 three-character categories all of which were subdivided resulting in over 4000 valid codes.

It was originally devised as an instrument to provide the best possible basis for accommodating current systems and future developments for data on surgical operations. As well as maintaining the planned objective, the fourth revision also incorporated two further general aspects. It provided a definition of an operative procedure and outlined the concept of MAIN operation during an episode of care.

From 1995 a review of OPCS-4 was completed consulting with users to identify future need and inform future strategic direction.

In 2002 a project to develop an up to date intervention classification was commissioned by the Information Policy Unit (IPU). A proposal on behalf of the former NHS Information Authority and the IPU to produce a requirement for the development of a new classification was considered by the Information Standards Board on 19 April 2002 who then submitted their recommendations to Sir John Pattison and the National Information Policy Board (NIPB) for their approval. On 4 July 2002 the NIPB approved the proposal for this work to go ahead.

The former NHS Information Authority initiated the project to deliver a new intervention classification to replace OPCS-4.2 to support the DH Financial Flows project known as Payment by Results. A review of this project was undertaken in March 2005 with the migration of the project to NHS Connecting for Health on 1 April 2005. The decision was taken at this stage to develop and enhance OPCS-4.2 to meet the needs of the Payment by Results programme which relies on detailed and accurate coding.

Consequently, OPCS-4.2 was enhanced during 2005-6 to support delivery of an updated classification for implementation across the NHS from April 2006. The project was completed in close collaboration with the Department of Health and with the NHS Information Centre for health and social care (IC) revising Healthcare Resource Groups (HRGs). In addition, input was received from clinical members of the clinical Expert Working Groups co-ordinated by the IC, which represented the Royal Colleges and professional associations. The result was OPCS-4.3, reflecting changes in clinical care in recent years enabling clinicians, in cooperation with clinical coders, to better describe patient care information. As a result this improved the quality of clinical procedural data collected by the NHS.

At the end of the project the responsibility for the development and maintenance of the OPCS-4 classifications was transferred to the NHS Connecting for Health national Clinical Classifications Service, now known as the Terminology and Classification Delivery Service.

Since September 2007, the Terminology and Classifications Delivery Service has made it easier for stakeholders to provide requests for change and track their progress with the launch of the online OPCS-4 Requests Portal. This was designed so anyone could submit their suggestions whenever it suited them.

The OPCS-4.5 release of the classification was the first which included requests for change received through the portal from stakeholders of the NHS. The OPCS-4 Requests Portal continues to provide the mechanism for all stakeholders to submit their requests for change. ~~https://isd.hscic.gov.uk/rsp/~~https://isd.digital.nhs.uk/rsp/

The development and maintenance of the classification is undertaken by the Terminology and Classifications Delivery Service at NHS England and will continue until further notice.

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 ~~n~~National ~~c~~Clinical ~~c~~Coding ~~s~~Standards. They provide classification expertise to inform coder/doctor dialogue. Clinical coders must abide by local and national confidentiality policies and codes of practice as a breach may lead to disciplinary action, a fine or, in the case of a breach of the Gender Recognition Act 2004, possible prosecution.

~~Hospital provider spell and care~~Care professional admitted care episode and Hospital provider spell

A clinical coder must assign OPCS-4 codes to the procedures recorded in the medical record for each care professional admitted care episode (hereafter referred to as ~~'episode' within the National Clinical Coding Standards reference book) within~~'episode') within the hospital provider spell for the Admitted Patient Care (APC) Commissioning Data Set (CDS) (which includes day cases).

A hospital provider spell may contain a number of episodes and the definitions for these terms are found in the NHS Data Model and Dictionary at: http://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.

An episode can be a consultant episode (hospital provider), a midwife episode or a nursing episode. ~~The~~ This term replaces the previous term 'finished consultant episode' commonly abbreviated to "FCE" which was 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://www.datadictionary.nhs.uk/ ~~NHS Data Model and Dictionary (datadictionary.nhs.uk)~~

Emergency Care Department attendance – Decision to Admit

The Emergency Care Commissioning Data Set (ECDS) is one of the mandated data flows for Health Care Providers across the NHS, England. In CDS V6-2-3 Type 011 – Emergency Care CDS emergency care attendances were mandated to flow nationally from 01-08-17. See DCB0092-2062 for more information.

All activity occurring under the responsibility of the Emergency Care Department is part of the Emergency Care Department Attendance and coded as such, including when the patient temporarily leaves the Emergency Care Department, e.g. for an X-ray.

When the patient's care contact originates as an Emergency Care Department Attendance, but later a clinical decision is made to admit the patient to a Health Care Provider, this is described as a 'decision to admit'. The 'Decided to admit date' and 'Decided to admit time' is recorded at the time when the clinical decision to admit is made.

The 'Decided to admit date' and 'Decided to admit time' or 'Admission date' trigger the start time for an episode within the Admitted Patient Care CDS.

Following the decision to admit any recorded activity from that point on becomes part of the Admitted Patient Care CDS requiring the application of ICD-10 and OPCS-4 codes, including:

- When the decision to admit is made immediately on the patient presenting to the Emergency Care Department, including when the patient is subsequently taken to an Operating Theatre before ward admission
- When a decision to admit is made but the patient is temporarily accommodated in the Emergency Care Department or elsewhere but remains waiting in the nursing care of the Emergency Care Department for longer than is appropriate for his/her condition before moving to a ward (i.e. a lodged patient).

It is important that this activity data is complete and accurate to avoid inaccuracies or data duplication in CDS flows.

When the patient's care contact originated as an Emergency Care Department Attendance but there is no evidence when the clinical decision to admit was made, the Health Care Provider will need to find a local solution to ensure this information is recorded. This also triggers the start time for the coding department to apply the codes for Admitted Patient Care CDS data flows.

DATA QUALITY

Medical record

A health record (hereafter referred to as 'medical record') is defined in the Data Protection Act 2018 as a record which consists of data concerning health, and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates. The health record can be held partially or wholly electronically or on paper.

The health record (commonly referred to as the medical record and used hereafter) is the source documentation for the purposes of clinical coding. TheIt is a medico-legal document and the responsible consultant, or healthcare practitioner, is accountable for the clinical information they provide.record in the medical record. It must accurately reflectneeds to be complete, accurate, relevant, accessible and timely to 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 episode within the hospital provider spell.
The medical record can be handwritten or digital and may be held in paper or, more commonly electronic format as NHS trusts update and improve their systems to adopt Electronic Patient Records (EPR) systems in hospitals.

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 andworksheets, 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 OPCS-4 code(s) and the production of robust health care information.

Any of these sources may be accessed for coding purposes. The clinical coder expects to find all relevant clinical information in the medical record and attributed to the relevant episode within the hospital provider spell.

The accuracy, completeness, legibility and timeliness of the information recorded in the medical record is therefore critical to the coding process. As the medical record is the source of truth for the purposes of clinical coding it is recommended that the clinical coder has access to the full medical record in order to extract all relevant information to support the correct assignment of OPCS-4 code(s) to produce consistent, high-quality and comparable data.

The Nnational Cclinical Ccoding Sstandards cannot provide direction to compensate for deficiencies in the documentation or coding process.

When the medical record does not contain sufficient information to assign a code, the clinical coder must consult the responsible consultant (or their designated representative[1]).

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

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

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

See also: https://www.england.nhs.uk/long-read/high-quality-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~~leverage 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.

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.

[1] 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.

Further information on information governance can be found at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance

Clinical coding audit

Coded clinical data are audited against Nnational Cclinical Ccoding Sstandards. 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 and training 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:

- areAre up-to-date
- evidenceEvidence local agreements and implementation
- haveHave been applied consistently
- doDo not contravene Nnational Cclinical Ccoding Sstandards.

TerminologySNOMED CT to OPCS-4 cross-maps

Health care providers that have implemented electronic health recordsan EPR system and athe clinical terminology such as SNOMED CT can use linkages the national maps between the terminologySNOMED CT UK Edition and OPCS-4 known as 'cross-maps'. The maps are designed to enable the clinical codingsupport those organisations with EPR systems to fulfil the mandatory requirement for collection and reporting of electronic health records.intervention and procedure data using OPCS-4

These maps support the derivation of classification codes directly from SNOMED CT concepts recorded by the clinician in the EPR. They are incorporated in software to present the OPCS-4 code(s) attached to a SNOMED CT concept, for validation by the clinical coding expert. Four different types of map are provided to accommodate the different circumstances that may influence OPCS-4 code assignment, see the SNOMED CT to Classifications Maps Page on Delen for more information.

These cross-maps are semi-automated with default and, where appropriate, alternative OPCS-4 target codes are provided. The default OPCS-4 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 OPCS-4 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 NHS UK SNOMED CT Clinical Edition biannual releases. They are designed to support those organisations with electronic health systems to fulfil the mandatory requirement for collection and reporting of intervention and procedure data using the NHS Information Standard, OPCS-4.~~

The classification ~~cross-~~maps are compiled by the Terminology and Classifications Delivery Service to reflect the rules and conventions of OPCS-4 as well as ~~the~~these ~~n~~National ~~c~~Clinical ~~c~~Coding ~~s~~Standards ~~contained in this standards' reference book~~.

~~The cross-maps~~The major releases of SNOMED CT UK Edition include the OPCS-4 map files which are available for download via the Technology Reference Data Update Distribution (TRUD) service following registration at the following website:
~~https://isd.hscic.gov.uk/trud3/user/guest/group/0/home~~
https://isd.digital.nhs.uk/trud/user/guest/group/0/home

Coding Uniformity

Uniformity means that whenever a given procedure performed during an episode is coded, the same code(s) is always used to represent that procedure. Uniformity is essential if the information is to be useful and comparable.

General ~~rules~~principles for accurate selection of codes apply:

- Code the minimum number of codes which accurately reflect the patient's interventions/procedure(s) performed during the episode.
- Code each procedure to the furthest level of specificity, i.e. fourth character, which is available in the classification and supported by the clinical information in the medical record.

Three dimensions of coding accuracy

- **Individual codes**

  Each procedure should have the correct code assignment. An individual patient may have many procedures. Consequently, a coded record for an 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 procedures performed during an episode, 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

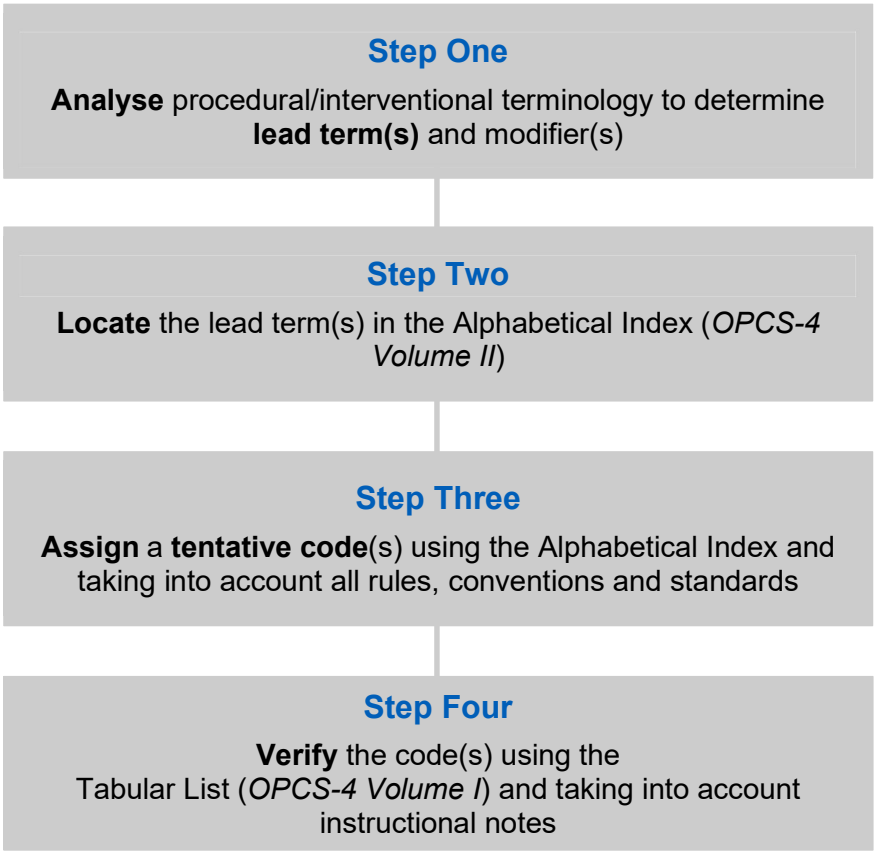
procedure incorrectly in terms of clinical coding rules and standards even though the individual codes selected are correct.

- **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 main procedure. ***See PRule 2: Single procedure analysis and multiple coding.***

The four-step coding process

The four staged process that make up the act of coding is designed to ensure appropriate and consistent code assignments. The coder is required to use OPCS-4 Volume II, Alphabetical Index and Volume I, Tabular List and be trained in the use of OPCS-4 and the context in which it is used.
The four-step coding process is the key to ensuring correct use of OPCS-4 and accurate coding of the procedural 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 in training using national core curriculum training materials.



HOW TO USE THIS PUBLICATION

The content is split into distinct sections so that it is clear whether the rule, convention or standard must be applied throughout the classification, or if it should be applied throughout a chapter or if it is specific to a code(s) or procedure.

All rules, conventions and standards 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 reference numbers are specific to each section, as explained below, but all are preceded by the letter '**P**' for 'procedure' to indicate that the rule, convention, or standard is applicable to OPCS-4.

Where there is no section for a chapter this means there are no standards or guidance specific to the chapter, e.g., Chapter F Mouth.

~~NATIONAL CLINICAL CODING STANDARDS OPCS-4 REFERENCE BOOK~~

~~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 OPCS-4 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 Terminology and Classifications Delivery Service.~~

~~As the main emphasis of clinical coding is data quality and accuracy this reference bookfocusses on the clinical coding standards that must be applied when assigning OPCS-4 codes.~~

It is important that users understand how each section should be applied when coding.

Supplementary Information for OPCS-4

~~It is important that coders possess knowledge of the anatomy of the human body and that they are aware of the methods and processes used when a procedure/intervention is performed on a patient. Therefore, a~~A separate reference document containing supplementary information about more complex or less well known procedures accompanies ~~this reference book.~~these standards. There is a host of reference sources available to coders if they wish to find out how a procedure is performed, such as surgical ~~text books~~textbooks, the internet and of course the wealth of knowledge that exists within clinical staff at Trusts. More information on the use of the OPCS-4 Supplementary Information can be found within the document which can be downloaded from the Publications & Resources page on Delen.

Where supplementary information about a procedure within a standard or guidance is available, this will either be identified with a book icon in the title of the standard, e.g.

PCSA4: Cortical mapping (A11.4) 

Or as a blue icon in the top right of the guidance box, e.g.

V02.1 Posterior calvarial release is usually performed as the first stage of a staged procedure and a more substantial remodelling procedure will be performed at a later date. ***See PGCS18: Staged procedures***. 

~~Structure of the OPCS-4 reference book~~

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

~~All rules, conventions and standards 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 reference numbers are specific to each section of the reference book, as explained below, but all are preceded by the letter '**P**' for 'procedure' to indicate that the rule, convention or standard is applicable to OPCS-4.~~

~~Where there is no section for a chapter this means there are no standards or guidance specific to the chapter, e.g. Chapter F Mouth.~~

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

Rules of the OPCS-4

Rules of the OPCS-4 apply throughout the classification and the clinical coder must be aware of these rules in order to code with consistency and accuracy.

A rule that a coder must comply with is presented in a grey box. Explanatory information about the rule is presented in a white box.

The unique identifiers for rules begin with '**PRule**'~~,~~ and are followed by the number of the rule and the title (e.g~~.~~ **PRule 7: Subsidiary Chapters Y and Z**).

Conventions of the OPCS-4

Conventions of the OPCS-4 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.

Conventions of the OPCS-4 are presented within a grey box.

The unique identifiers for conventions begin with '**PConvention**' followed by the number of the convention and the title (e.g. ~~.~~ , **PConvention 2: Instructional notes and paired codes**).

Coding Standards

A c~~C~~oding s~~S~~tandard 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.

PGCS6: Radical operations
When coding radical operations: • Code assignment must fully reflect the procedure(s) performed during the radical operation • Instructional ***Notes*** must be applied in order to fully reflect all procedures performed • Any uncertainty as to what procedures were performed during the radical operation must be clarified with the responsible consultant in order to ensure correct code assignment.
Radical operations generally involve procedures on multiple sites. This may include the removal of blood supply, lymph nodes and adjacent structures of a diseased organ and is often used in the treatment of malignant neoplasms. Radical operations are generally not listed in the Alphabetical index or the Tabular list of OPCS-4.

There are three types of Standard:

- **General coding standards**

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

The unique identifiers for general coding standards begin with '**PGCS**' followed by the number of the standard and the title (e.g~~.~~., **PGCS2: Diagnostic versus therapeutic procedures**).

- **Chapter standards**

  Chapter standards are located at the beginning of each OPCS-4 chapter ~~of the reference book~~ and are applicable throughout the chapter. Note that not all chapters will have chapter standards.

  The unique identifiers for chapter standards begin with '**PChS**' followed by the chapter letter, the number of the standard and the title (e.g~~.~~., **PChSL3: Insertion of stents and stent grafts**).

- **Coding standards**

  Coding standards are located throughout each OPCS-4 chapter ~~of the reference book~~ and applicable to specific procedures/interventions, codes, categories, or blocks of codes. Coding standards are~~, generally,~~ listed in code, category, or range order.

  The unique identifiers for coding standards begin with '**PCS**' followed by the chapter letter, the number of the standard and the title (e.g~~.~~., **PCSA1: Guide tube anterior cingulotomy (A03.1)**).

Coding guidance

Coding guidance is advice or information 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 reference numbers or titles. e.g.

> Pessaries inserted into the vagina for antiseptic, contraceptive or abortifacient purposes are coded to Chapter Q.

Examples

Examples are included ~~throughout the reference book~~where necessary to illustrate the correct application of a rule, convention or standard and are provided after guidance to illustrate the points made. They are only included when an example of the practical application of codes may aid the coder in understanding the rule, convention or standard. The codes reflect the procedural statement given within the example. Where required a rationale is provided.

Examples are not national standards and should only be used as an aid to coding. Clinical coding must always be based on the information contained within the rule, convention or standard.

Further examples of how standards can be applied can be found in the current ICD-10 and OPCS-4 Exercise and Answer Booklets. These are available to anyone on request via information.standards@nhs.net.

References

References direct the user to a pertinent standard or guidance ~~elsewhere~~ in ~~the reference book~~a different section. 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.

Parathyroid washout (B16.4)
B16.4 Parathyroid washout is a nuclear medicine imaging procedure and a code from categories **Y93, Y94, Y97** and **Y98** must not be assigned in addition. ***See PCSU3: Nuclear medicine imaging procedures.***

Appendices

The appendices contain additional guidance and information that is not appropriate for inclusion within the main content ~~of the reference book~~, for example because it is a long list of guidance or is applicable to multiple chapters.

Index of standards

The Index of standards lists all rules, conventions, general coding standards~~,~~ and chapter standards ~~and coding guidance~~ in the order they appear ~~in the reference book.~~ It can be used to locate a specific standard ~~in the reference book~~.

Summary of Changes

The summary of changes lists each change that has been made between the previous and current release of the ~~reference book~~National Clinical Coding Standards for OPCS-4 in the

order that ~~they appear in~~ the ~~reference book.~~change appears. Where appropriate, a rationale is provided to indicate why a standard has been introduced, updated, or deleted. ~~updated or deleted.~~

Updating the ~~reference book~~National Clinical Coding Standards for OPCS-4

Updated releases of the ~~reference book~~National Clinical Coding Standards for OPCS-4 may contain new or updated rules, conventions, standards and guidance~~. Existing content in the previous release of the reference book~~ or they may have been deleted. In each case the updates are made in a consistent manner and are identified in the summary of changes. Users can also refer back to previous ~~reference books~~versions to see how the standard and codes were applied historically.

New Rules, Conventions and Standards

A new rule, convention, general coding standard and chapter standard is added at the end of the relevant section with a new unique identifier and title.

A new coding standard within a chapter is added in code, category or range order to reflect the location of the code(s) that the standard applies to in the OPCS-4 Tabular List. The new entry is given a new unique identifier and title. This means that the unique identifiers for coding standards within a chapter may not always be listed sequentially.

The unique identifiers and title of all new entries can be referenced in the Index of standards.

Updated rules, conventions and standards

When a rule, convention or standard is updated, the necessary changes are made to the existing text and the unique identifier remains the same.

Deleted Rules, Conventions and Standards

A rule, convention or standard is deleted when it is no longer ~~to be applied~~applicable or has been superseded. Deleted entries are removed ~~from the reference book~~.

New, updated and deleted guidance and references

New guidance and references are added in the most relevant location. They are deleted if no longer required. Guidance and references are updated by making the appropriate changes to the existing text of the guidance or reference.

CHAPTER J OTHER ABDOMINAL ORGANS – PRINCIPALLY DIGESTIVE
(J01–J77)

Chapter standards and guidance

PChSJ1: Operations on blood vessel of liver

Where an operation on a blood vessel of the liver does not have a specific code in Chapter J Other abdominal organs – principally digestive, but a specific operation code exists in Chapter L Arteries and Veins, the Chapter L code must be assigned.

See also:
- ***PChSY1: Use of codes in Chapter Y***
- ***PCSZ1: Site codes***

Example:

Percutaneous transluminal hepatic vein occlusion using image control.

L99.5 Percutaneous transluminal occlusion of vein NEC
Y53.9 Unspecified approach to organ under image control
Z39.6 Hepatic vein

CHAPTER K HEART
(K01–K78)

Coding standards and guidance

PCSK3: Coronary arteriography with fractional flow reserve measurement or pressure wire studies and coronary angioplasty using fractional flow reserve

When measurement of Fractional Flow Reserve (FFR), or pressure wire studies is performed at the same time as coronary arteriography, the following codes and sequencing must be used:

K63.4 - K63.6 Coronary arteriography
K51.8 Other specified diagnostic transluminal operations on coronary artery
Y44.2 Monitoring of pressure in organ NOC

Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

When coronary angioplasty and/or insertion of stent(s) into the coronary artery/arteries are performed using FFR, or pressure wire studies the following codes and sequencing must be used:

Code classifying angioplasty and/or insertion of stent

Y14.- Placement of stent in organ NOC (when a combination of stents have been inserted)
Y37.2 Introduction of substance into organ using drug-eluting balloon NOC (where a drug-eluting balloon has been used)
Y44.2 Monitoring of pressure in organ NOC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control**

See also:

- ***PCSY15: Drug-eluting balloons (Y37.2)***

PCSK5: Insertion of ventricular assist device (K54 and K56.2)

For the insertion of a ventricular assist device (VAD) using an open approach assign the following codes:

K54.- Open heart assist operations
Y70.5 Temporary operations

For the insertion of a ventricular assist device (VAD) using a percutaneous approach assign the following codes:

K56.2 Transluminal insertion of heart assist system NEC
Y53.- Approach to organ under image control or **Y68.- Other approach to organ under image control** (if image control is used)
Y70.5 Temporary operations

CHAPTER S SKIN
(S01–S70)

Chapter standards and guidance

PChSS2: Coding skin flaps and harvests

Skin flaps must be coded as follows:

Local skin flaps:

- When a specific body system skin flap code is available or when the flap is to the skin of the sites listed at the beginning of Chapter S, assign the appropriate code from the relevant **body system chapter**
- Flap code from Chapter S Skin (if doing so adds further information)*
- Chapter Z site code identifying the specific site/organ being reconstructed or repaired (if this has not already been identified within the body system code)
- **Z94.- Laterality of operation** (if applicable)

Other skin flaps:

- When a specific body system skin flap code is available or when the flap is to the skin of the sites listed at the beginning of Chapter S; assign the appropriate code from the relevant **body system chapter**
- Flap code from Chapter S Skin (if doing so adds further information)*
- Chapter Z site code identifying the specific site/organ being reconstructed or repaired (if this has not already been identified within the body system code)
- **Z94.- Laterality of operation** (if applicable)
- Chapter Y code(s) identifying the type of flap harvested and the site of harvest (unless this is identified within the body system code)
- Chapter Z site code identifying the site of the harvest (if this has not already been identified within the Y harvest code)
- **Z94.- Laterality of operation** (if applicable).

* When coding skin flaps, if a specific body system skin flap code is not available or the flap is **not** to one of the skin sites listed in the ***Note*** at the beginning of Chapter S, do not assign a body system chapter code; begin by assigning the flap code from Chapter S.

See also: ***PChSS1: Enhancing body system codes using codes from Chapter S***

Local flaps have their donor areas touching at the borders or very near to the recipient site. There is no national requirement to assign harvest codes with local skin flap procedure codes; harvest codes can be captured if there is a local need to do so.

This standard has been amended to identify and differentiate the ways in which local skin flaps and other types of skin flaps are to be coded.

CHAPTER U DIAGNOSTIC IMAGING, TESTING AND REHABILITATION
(U01–U54)

Coding standards and guidance

PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37)

Coding diagnostic imaging procedures using body system chapter codes

When a specific code classifying a diagnostic imaging procedure is available in a body system chapter (Chapters A-T and V–W), for example **Q55.5 Transvaginal ultrasound examination of female genital tract, C87.1 Digital imaging of retina** and scanning codes within the range **R36–R43,** the body system chapter code **must** be used in preference to the codes within categories **U01–U21** and **U34–U37**.

The standard to only code diagnostic imaging procedures in an outpatient setting or if the patient has been admitted solely for the purpose of a procedure/intervention only applies to codes in categories **U01–U21** and **U34–U37** and categories **R36-R43**.

Additional codes from categories **Y97 Radiology with contrast** and **Y98 Radiology procedures** must not be assigned with body system chapter imaging codes.

See also *PCSR7: Obstetric scans (R36-R43)*.

Coding diagnostic imaging using codes from Chapter U

Codes in the range **U01–U21** and their extended categories **U34–U37** are only for use in an outpatient setting, or if a patient has been admitted solely for the purpose of a diagnostic imaging procedure/intervention. The exceptions to this standard are:

- **Magnetic Resonance Imaging (MRI)**
- **Computed Tomography (CT)**
- **U19.1 Implantation of electrocardiography loop recorder**
- **U19.7 Removal of electrocardiography loop recorder**
- **U20.1 Transthoracic echocardiography (TTE)**
- **U20.2 Transoesophageal echocardiography (TOE)**
- **U20.3 Intravascular echocardiography**
- **U20.4 Epicardial echocardiography**

These exceptions must always be coded on inpatient and outpatient episodes of care.

The '***Notes***' at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast** (if used) are required - ***see*** *PCSU2 Radiological contrast and body areas (Y97-Y98)**.***

Categories **Y97** (if used) and **Y98** must also be assigned in addition to codes **U36.2 Positron emission tomography with computed tomography NEC** and **U36.3 Single photon emission computed tomography with computed tomography NEC.**

The codes in categories **U01–U21** ~~and **U34–U37**~~ that classify nuclear medicine imaging procedures do not require the addition of codes from categories **Y97** or **Y98** – ***see*** *PCSU3 Nuclear medicine imaging procedures**.***

Diagnostic imaging of one body area using one method of imaging
When **one** body site alone is scanned and this can be indexed to a code range from **U01–U18, U35** or **U37** assign the following codes**:**

- Specific body system code from **U01–U18**, **U35** or **U37**
- **Y97 Radiology with contrast** (if used)
- **Y98.1 Radiology of one body area (or < 20 minutes)**
- Z site code (if doing so adds further information).
- **Z94.- Laterality of operation** (if applicable)

An indexable body system code must only be recorded **once** for each **visit** to the radiology department documented in the patient's medical record.

Diagnostic imaging of one body area using multiple different types of imaging and diagnostic imaging of multiple body areas
When one body area is scanned during a single visit to the radiology department using multiple types of imaging **or** when more than one area is scanned during a single visit to the radiology department using either the *same* or *different* types of imaging assign the following codes and sequencing for each different type of imaging used:

- The specific fourth character at **U21 Diagnostic imaging procedures** or **U36 Other diagnostic imaging procedures**
- **Y97 Radiology with contrast** (if used)
- **Y98 Radiology procedures** (with the fourth-character selection being reliant upon the number of areas scanned or duration of the scan)
- Z site code(s)
- **Z94.- Laterality of operation** (if applicable)

The exception to this is *PCSU8: Cardiac computed tomography for calcium scoring and cardiac computed tomography angiography (U10.2)* and *PCSU9: Bone densitometry (U13.1)*

Specified diagnostic imaging procedures not classifiable to body site or system categories
Where a specific type of imaging is not classifiable at fourth-character level within categories **U01–U18**, **U35** or **U37**, but is available within categories **U21 Diagnostic imaging procedure** or **U36 Other diagnostic imaging procedure** assign the following codes and sequencing:

- The specific fourth character at **U21 Diagnostic imaging procedures** or **U36 Other diagnostic imaging procedures** (excluding **U21.8**)
- **Y97 Radiology with contrast** (if used).
- **Y98 Radiology procedures** (with the fourth-character selection being reliant upon the number of areas scanned)
- Z site code(s)
- **Z94.- Laterality of operation** (if applicable)

Where a specific type of imaging cannot be classified at fourth-character level within categories **U01–U18**, **U35** or **U37**, and there is no fourth-character code available in category **U21** or **U36** assign the following codes and sequencing:

- Residual subcategory **.8** from categories **U01–U18**
- **Y97 Radiology with contrast** (if used).
- **Y98 Radiology procedures** (with the specific fourth-character selected being reliant upon the number of areas scanned).

Code **U21.8 Other specified diagnostic imaging procedures** must not be assigned in these circumstances.

Notes instructing the use of **Y97** and **Y98** are currently missing from codes **U36.2 Positron emission tomography with computed tomography NEC** and **U36.3 Single photon emission computed tomography with computed tomography NEC** will be corrected in the next version of OPCS-4.

PCSU2: Radiological contrast and body areas (Y97-Y98)

The '***Notes***' at categories **U01–U21** and **U34–U37** indicate when additional codes from category **Y98 Radiology procedures** and **Y97 Radiology with contrast**, if used, are required.

Codes from categories **Y97 Radiology with contrast** or **Y98 Radiology procedures** must not be assigned in addition to nuclear medicine codes in categories **U01–U21** ~~The codes in categories **U01–U21** and **U34–U37** that classify nuclear medicine imaging procedures do not require codes from categories **Y97** or **Y98**~~ – ***see*** *PCSU3: Nuclear medicine imaging procedures.*

Codes from **Y97 Radiology with contrast** must always be assigned *after* the codes for the specific scan and *before* codes from **Y98 Radiology procedures.**

OPCS-4 codes from categories **Y97 Radiology with contrast** and **Y98 Radiology procedures** must not be used with the diagnostic imaging codes from the body system Chapters A–T and V–W.

Y97 Radiology with contrast:

Codes within category **Y97** must only be assigned if it is stated in the patient's medical record that the imaging procedure has been performed using contrast media. Codes in category **Y97** must be used as follows:

- **Y97.1 Radiology with pre and post contrast** is assigned when image(s) are taken before contrast is given and then again after contrast has been introduced.
- **Y97.3 Radiology with post contrast** is assigned when image(s) are taken after contrast is given.
- When only 'radiology with contrast' is stated in the medical record **Y97.3 Radiology with post contrast** must be used as the default.

The following codes from category **Y97** must not be used:

- **Y97.2 Radiology with pre contrast** as this classifies image(s) taken before contrast is given.
- **Y97.8 Other specified radiology with contrast** and **Y97.9 Unspecified radiology with contrast** as the type of contrast would be coded using **Y97.1** or **Y97.3**.

Y98 Radiology procedures:

Codes within **Y98** are used to classify the following:

- number of body areas scanned/examined or the duration of the scan
- mobile and intraoperative scans
- extensive patient repositioning.

Codes **Y98.1**, **Y98.3** and **Y98.5** are used interchangeably to identify the time duration of the scan *or* the number of body areas examined during the scan.

When coding ultrasound and contrast fluoroscopy, it is the time duration and not the number of body areas that defines which code from category **Y98** must be assigned.

In the case of magnetic resonance imaging, computed tomography and plain x-ray, it is the number of body areas scanned that defines which code must be assigned, irrespective of the time duration taken to perform these scans.

The 'body areas' referred to in the codes in category **Y98** relate to the following nine anatomical regions of the body. These must be used as a guide during code assignment:

- **Head**
- **Neck (including cervical spine)**
- **Thorax (including thoracic spine)**
- **Abdomen (including lumbar spine)**
- **Pelvic region (including all organs in genitourinary system, sacral spine and groin)**
- **Right leg**
- **Left leg**
- **Right arm**
- **Left arm.**

It is important the default code **Y98.1 Radiology of one body area (or < 20 minutes)** is selected if the area /duration of scan is not specified. It is the responsibility of the clinician to provide this level of detail in the source document.

Where different methods of radiological imaging are carried out, each method must have a code from **Y98 Radiology procedures** assigned.

Y98.6 Mobile and or intraoperative procedures of any/all body areas and **Y98.7 Extensive patient repositioning to obtain required image series** are used as additional codes to any other codes in category **Y98** when this information has been provided in the medical record. It is therefore permissible for more than one code to be assigned from category **Y98 Radiology procedures** on the same episode of care.

It is important to be very precise about radiology procedures, as a common term like 'x-ray' can apply to diverse procedures such as: plain film x-ray, contrast media x-ray, fluoroscopic x-ray, mammography x-ray or CT scan x-ray.

Care must be taken when assigning codes for procedures which are performed using a fluoroscopic approach and contrast fluoroscopy scans, as the latter is simply a diagnostic image of a body area.

PCSU3: Nuclear medicine imaging procedures (U01–U21 and U34–U37)

Nuclear medicine imaging codes in the range **U01–U21** and their extended categories **U34–U37** are only for use in an outpatient setting, or if a patient has been admitted solely for the purpose of a nuclear medicine imaging procedure**.** The exceptions to this standard are:

- **Positron Emission Tomography (PET)**
- **Single photon emission computed tomography (SPECT)**
- **Positron emission tomography with computed tomography (PET/CT)**
- **Single photon emission computed tomography with computed tomography (SPECT/CT)**

These exceptions must always be coded on inpatient and outpatient episodes of care.

Codes that classify nuclear medicine procedures within categories **U01–U21** and **U34–U37** are identified by the presence of the '***Note***' indicating to use a subsidiary code to identify **Y93 Gallium-67 imaging** or **Y94 Radiopharmaceutical imaging**. These subsidiary codes must be used if radiopharmaceutical imaging substances are used during a nuclear medicine imaging procedure.

U36.2 Positron emission tomography with computed tomography NEC and **U36.3 Single photon emission computed tomography with computed tomography NEC** require the addition of a code from **Y98 Radiology procedures** in order to capture the number of body areas scanned by the CT element of the procedure. **Y98** must be sequenced following **Y93** or **Y94**.

Codes from categories **Y97 Radiology with contrast** or **Y98 Radiology procedures** must not be assigned in addition to nuclear medicine codes in categories **U01–U21** , ***see*** *PCSU1 Diagnostic imaging procedures (U01–U21 and U34–U37)* ***and*** *PCSU2: Radiological contrast and body areas (Y97-Y98)****.***

See also *PCSU4: Myocardial/Cardiac perfusion scan (U10.6 and U11.5)****.***

Nuclear medicine imaging procedures available in the main body system chapters are **B16.4 Parathyroid washout** and **T91.2 Scanning of sentinel lymph node**. Codes from categories **Y93, Y94, Y97** and **Y98** must not be assigned in addition to the nuclear medicine imaging codes contained within the body system chapters.

Examples:

Positron emission tomography with computed tomography (CT) scan of the liver using yttrium 90 microspheres.

U36.2 Positron emission tomography with computed tomography NEC

Note: Use subsidiary codes to identify gallium-67 imaging (Y93), radiopharmaceutical imaging (Y94)

Y94.8 Other specified radiopharmaceutical imaging
Y98.1 Radiology of one body area (or < 20 minutes)
Z30.1 Liver NEC

The use of codes in category **Y98** to classify the number of body areas scanned within PET CT and SPECT CT procedures has been added to ensure appropriate HRG generation following discussion with the National Casemix Office. Both the number of body areas scanned and the radionuclide used are required.

National Clinical Coding Standards OPCS-4