Clinical Coding Standard Consultation

OPCS-4 Settings (Multiple Standards)

This proposed standard is for review and comment and must not be used for coding patient episodes of care.

Please review the standards in conjunction with the document *Guidelines for External Review of Clinical Coding Standards* and enter any comments about this proposed standard into the comments box at the end of the consultation.

Reason for development of new standard or amendment to existing standard

In order to ensure that OPCS-4 is not setting-dependent, it is desirable to remove the majority of instructions that mean that certain codes may only be used in a certain setting (inpatient / outpatient / daycase) from the OPCS-4 National Clinical Coding Standards, and to remove statements such as “admitted solely for the purpose of”. In some cases removal of this language is not desirable or advised, due to possible issues with coding practice or HRG evaluation: such standards are not included in this document.

This document offers suggested changes to the current OPCS-4.8 National Clinical Coding Standards to comply with the desired removal of references to “settings” or “solely admitted” language. (.)

There are a number of standards in which only the examples are affected by the change in terminology, so they have not been included in the consultation. In these examples, the change removes the phrase “admitted for” and replaces it with “undergoes”, e.g. *Patient ~~admitted for~~ undergoes left sided hemicolectomy and formation of loop ileostomy.* The standards with applicable examples are:

- **PConvention 3: Abbreviations**
- **PGCS3: Incomplete, unfinished, abandoned and failed procedures**
- **PGCS5: Unintentional procedures**
- **PGCS18: Staged procedures**
- **PCSM6: Catheterisation of the bladder (M47)**
- **PChSV3: Instrumented spinal fusions with decompression and bone graft**
- **PCSW5: Replacement of infected prosthetic joint replacement** (“Readmitted” was retained because it was a relevant part of the description of this example)

Standard proposal – delete guidance

PCSD1: Attachment of bone anchored hearing prosthesis (D13)

Codes **D13.1 First stage insertion of fixtures for bone anchored hearing prosthesis**, **D13.2 Second stage insertion of fixtures for bone anchored hearing prosthesis** and **D13.5 One stage insertion of fixtures for bone anchored hearing prosthesis** do not include the fitting of the bone anchored hearing aid itself.

The fitting of a bone anchored hearing aid must be coded separately using **D13.6 Fitting of external hearing prosthesis to bone anchored fixtures.**

~~In most cases, the hearing aid is inserted during an outpatient appointment.~~

Standard proposal – delete standard and create new standard

~~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.~~

PCSE-: Ventilation support (E85)

Codes within category **E85 Ventilation support** must always be assigned when ventilation support is performed. However, each different type of ventilation support must only be coded once per Consultant Episode.

Standard proposal – update standard (changes the meaning of the standard)

PChSG1: Failed intubation at upper gastrointestinal tract endoscopy

When a patient ~~admitted for~~ undergoes a gastrointestinal tract endoscopy and the patient is unable to tolerate the scope and statements such as 'failed intubation' ~~is~~ are 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~~ undergoes 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~~ undergoes 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.

Standard proposal – update standard (changes the meaning of the standard)

PCSG3: Insertion of nasogastric feeding tube (G47.8)

~~Insertion of a nasogastric (NG) feeding tube must only be coded when a patient is admitted solely for the purpose of insertion. In these instances, the following OPCS-4 code must be used:~~
~~**G47.8 Other specified intubation of stomach**~~
Insertion of a nasogastric (NG) feeding tube is classified at code **G47.8 Other specified intubation of stomach**.

Standard proposal – delete standard

~~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.~~

Standard proposal – update standard (changes the meaning of the standard)

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
Y53.- Approach to organ under image control (where used)
Y95.- Gestational age

R37.3 Fetal biometry is always carried out using ultrasound, therefore a code from category **Y53** is not required to identify 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.~~

Standard proposal – delete standard

~~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.~~

Standard proposal – delete standard and create new standard

~~PCSU5: Diagnostic tests (U22-U33 and U40)~~

~~Codes in categories **U22-U33** and **U40** 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).***~~

PCSU-: Electroencephalograph telemetry (U22.1)

U22.1 Electroencephalograph telemetry must always be coded whenever it is performed.

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).***

Standard proposal – delete standard

~~**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.~~

Feedback and comments

Please provide feedback to the proposed standard by completing the box below

The deadline for submitting feedback is Friday 5th October.

Thank you for taking the time to review and provide feedback for this consultation. The final standard will be published in the next version of the National Clinical Coding Standards reference book.