

Stereotactic radiosurgery  
on tissue of brain

Bypass Artery Carotid NEC

Double lung transplant

Diagnostic endoscopic ultrasound  
examination of peritoneum



# National Clinical Coding Standards OPCS-4 (2026)

Accurate data for quality information

# National Clinical Coding Standards OPCS-4

Accurate data for quality information

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

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](#).

## 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 Classification of Interventions and Procedures (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 coordinated 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 2006, the classification has been regularly updated. The following table lists OPCS-4 versions and the financial year in which they were mandated for use:

<b>Financial Year</b>	<b>Version of OPCS-4</b>
Up to 31 March 2006	OPCS-4.2
1 April 2006 – 31 March 2007	OPCS-4.3
1 April 2007 – 31 March 2009	OPCS-4.4
1 April 2009 – 31 March 2011	OPCS-4.5
1 April 2011 – 31 March 2014	OPCS-4.6
1 April 2014 – 31 March 2017	OPCS-4.7
1 April 2017 – 31 March 2020	OPCS-4.8
1 April 2020 – 31 March 2023	OPCS-4.9
1 April 2023 – 31 March 2026	OPCS-4.10
1 April 2026 – until further notice	OPCS-4.11

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.

The overall governance for OPCS-4 is provided by the UK Digital Vocabularies (DigiVox) Strategy Board, which is comprised of the national informatics leads for all four UK member countries.

The UK Classifications Technical Advisory Committee, which is a sub-committee of the UK DigiVox Strategy Board, provides oversight of OPCS-4 content updates and compliance with editorial principles. The Committee is a panel of classification experts from the UK member countries.

## 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<sup>1</sup>).

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<sup>1</sup> 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.rcp.ac.uk/improving-care/resources/standards-for-the-clinical-structure-and-content-of-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
- 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 coding process

The coding process is the basis of clinical coding and is designed to ensure accurate and consistent OPCS-4 code assignment. It is based on the Four-step coding process which was designed for use with the paper-based version of OPCS-4.

The process utilises the functionality available in the NHS Classifications Browser which is the primary source for access to OPCS-4.

The process can be carried out using two methods:

- **The Classic method** replicates the Four-step coding process with slight alterations to suit its use in the NHS Classifications Browser.
- **The Search method** utilises the search facility, meaning that steps 2 and 3 must be done together

Steps 1 and 4 are the same in both methods.

Coders may favour one method over the other and may use a combination of the two methods. It is important to find a method that suits the user, that ensures accuracy, consistency and efficiency, and that importantly uses both the OPCS-4 Volume II - Alphabetical Index and Volume I - Tabular List.

These methods are summarised as follows:

Step	Classic method	Search method
1	<b>Analyse</b> procedural/ interventional terminology to determine lead term(s) and modifier(s)	
2	<b>Locate</b> the lead term(s) in OPCS-4 Volume II - Alphabetical Index	<b>Search</b> for the lead term(s) and <b>assign a tentative code(s)</b> using OPCS-4 Volume II - Alphabetical Index
3	<b>Assign a tentative code(s)</b> using OPCS-4 Volume II - Alphabetical Index	
4	<b>Verify</b> the code(s) to ensure appropriate code selection using OPCS-4 Volume I - Tabular List	

The full detail of each step is fully explored in training using national core curriculum training materials, and within the suite of documents that can be accessed on Delen.

## 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., **PCSZ2: Laterality of operation (Z94)**).

## 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 [support.digitalservices@nhs.net](mailto:support.digitalservices@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.

### 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.***

## 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:

- |                                 |  |
|---------------------------------|--|
| <b>Major</b>                    | - Total removal<br>Functional replacement<br>Transplant              |
| <b>Intermediate</b>             | - Partial removal<br>Partial destruction<br>Reconstruction<br>Repair |
| <b>Minor</b>                    | - Biopsy<br>Incision<br>Aspiration                                   |
| <b>Non-operative procedures</b> | - Injection<br>Examination<br>Scan/Imaging<br>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 considered where absolutely necessary. If a circumstance arises where a code description is considered obsolete, outdated or inaccurate (usually due to changes in clinical practice and knowledge) a full review of the issue is undertaken. The problem, an options appraisal, and recommendation(s) are provided to the OPCS-4 Editorial Committee for a decision. The support of the relevant professional body or clinician may also be required in these circumstances to provide appropriate clinical input.

In practice, the code is retired from 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 (ToCE) (used to analyse the equivalent codes in the current and previous releases of OPCS-4).

Where a three-character category is retired all the four-character codes within it are also retired. Retired codes and categories are represented as follows:

**R03.-**      **Category retired – refer to introduction**  
**X15.3**      **Code retired – refer to introduction**

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

**OPCS-4.11:**

E63.2	E63.3	E63.4	G80.3	H05.2	H06.1
H06.3	H06.5	H07.5	H08.2	H08.3	H08.6
H09.6	H10.1	H10.6	H11.6	H30.3	H30.4
H30.5	H44.3	H68.-	H69.-	H70.-	J17.-
J53.-	J74.-	L74.1	M10.5	M11.2	M11.3
M21.1	M27.-	M30.4	Q35.4	Q36.2	R40.2
T46.1	X35.1	Y76.1	Y76.2	Y76.3	Y76.4
Y76.6					

The OPCS-4.11 release saw an increase in the retirement of codes that are outdated or obsolete, including those due to changes to the classification of endoscopic and percutaneous endoscopic procedures.

**OPCS-4.10:**

P15.3	G80.2
-------	-------

**OPCS-4.9**

L99.1	M16.4	M28.1	M28.2	M28.3
-------	-------	-------	-------	-------

**OPCS-4.8:**

M06.4
-------

**OPCS-4.7:**

R03	X15.3
-----	-------

**OPCS-4.5:**

X63.-	X64.-
-------	-------

The retired categories and codes, their full descriptions and the rationale for their retirement are listed within the OPCS-4.11 ToCE Specification, available in the OPCS-4.11 data files on TRUD.

**See also *PRule 12: Codes at risk of being used in error***

### **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 only be used as a guide when assigning OPCS-4 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 is used to indicate the codes that may 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 was not revised between 2008 and 2025, however in OPCS-4.11, implemented in April 2026, additions have been made to reflect the ongoing use of eponyms by clinicians and the need to assist coders in assigning accurate OPCS-4 codes.

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 used with caution 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)***

### PRule 12: Codes at risk of being used in error

The codes contained within the database '**OPCS-4 codes at risk of being assigned in error**', hosted on Delen, must be used with caution. Before assigning a code from the list, coders must ensure that the code correctly classifies the procedure documented within the medical record.

During the development of OPCS-4.11, clinical input suggested that certain codes may be obsolete or erroneous. Analysis of Hospital Episode Statistics (HES) and consultation with coding departments (via the Clinical Coding Managers Workspace) confirmed that some codes were obsolete, inaccurate, or outdated. These were subsequently retired or altered in OPCS-4.11.

However, it was not possible to definitively confirm that all codes were obsolete, as some are still in use. To gather further evidence, a database of codes that are at risk of being used in error has been created to support their potential removal or modification in a future release.

The codes are categorised as follows:

- **Original purpose unclear**

The code has been present in OPCS-4 for a number of years, but the purpose of the code is not clear

- **Potentially clinically inaccurate**

Clinical feedback has indicated the code is clinically inaccurate but is still in use suggesting that source documentation reflects the code description

- **Potentially obsolete**

Clinical feedback has indicated that the procedure classified is no longer performed

- **Potentially outdated**

The code has been present in OPCS-4 for a number of years, but the procedure being described in the code description does not use contemporary language.

Each code also includes a reason for their potentially erroneous use.

The codes may be assigned if source documentation supports their use, but coding departments will be expected to submit anonymised documentation to [support.digitalservices@nhs.net](mailto:support.digitalservices@nhs.net) or our [Customer Service Portal](#) to help understand why and how they are being used.

The Terminology & Classifications Delivery Service will perform periodic data quality checks on the use of these codes. In cases where source documentation is missing, trusts will be contacted to determine the appropriateness of the code's use. Therefore, to proactively support this initiative, we encourage coding departments to conduct regular local data quality checks on their use of these codes.

***See also PRule 6: Retired categories and codes***

### **PRule 13: Section V Alphabetical Index of Common Procedures and Combinations**

When using Section V Alphabetical Index of Common Procedures and Combinations within Volume II – Alphabetical Index, coders must ensure the codes assigned fully reflect the procedure performed.

OPCS-4 codes must be assigned adhering to all relevant National Clinical Coding Standards even where these deviate from the listed codes. Examples where the additional codes may not appear within the Section V entry are:

- Laterality which must be assigned following **PCSZ2: Laterality of operation (Z94)**
- Approach codes, including image control. See **PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)** and **PCSY7: Approach to organ under image control (Y53, Y68 and Y78)**.

Care must also be taken where an eponym or surgical abbreviation is provided within Section V, see **PRule 8: Surgical eponyms** and **PRule 9: Surgical abbreviations**.

As additional codes may be added or removed to fully reflect a procedure, the sequencing provided within an entry is not intended to be prescriptive. Care must be taken to ensure that sequencing follows National Clinical Coding Standards and OPCS-4 Conventions.

Section V is provided to ensure consistent data is collected where a common procedure is documented in a way that is not easy to index, or a combination of codes are required to fully represent a common procedure.

The index entries do not follow the ‘what-where-how’ structure of Section I Alphabetical Index of Interventions and Surgical Procedures to enable more natural language to be used which can be searched in the NHS Classifications Browser.

### **Conventions used with Section V index entries**

Where any code from a category applies this appears as ‘.-’ at the end of the category, for example ‘**Y51.-**’. In principal/extended categories only the principal category will be listed but this means any code from either the principal or extended category is applicable.

Where a code is optional depending on how the procedure is documented these codes will appear in brackets within the entry, for example (**Y11.-**)

Abbreviations and alternative descriptions are included in brackets within the entry description, for example ‘Balloon dilation of ethmoid sinus (Balloon sinuplasty)’.

### **Feedback**

As this is a new section, we would like to gather feedback on its use throughout the year and make improvements where necessary. Please provide any feedback and suggestions for improvement via this [Microsoft Form](#).

To request additional entries please submit a request for change via the [OPCS-4 Request Submission Portal](#) as a minor change.

## 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. There will not be any entries under the lead term listed before the 'see' cross reference. For example:

Dilatation - see Dilation  
Syringing - see Irrigation

#### 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. For example:

Destruction - see also Photodestruction  
Excision Lesion - see also Excision site

*See also PConvention 4: Alphabetical index entries*

### 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.

The exception to this convention is **PChSW4: Coding bone grafts**

### **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

**PConvention 4: Alphabetical Index entries**

Section I Alphabetical Index of Interventions and Surgical Procedures is divided alphabetically by lead terms followed by modifiers.

Lead terms are generally the type of intervention/procedure performed or the interventional action, such as 'Ablation'.

Modifiers describe where the intervention/procedure has been done, i.e. the site, including any sub sites, and how the intervention/procedure has been done, such as 'laparoscopic', 'percutaneous', 'microwave' and 'stereotactic'.

Terms such as 'lesion' constitute a sub site. A lesion refers to any lump or bump, etc., that should not be present, e.g. cyst, tumour, ganglion abscess. An organ represents the site of the operation and refers to any anatomical part, either internal or external, e.g. stomach, brain, joint, skin.

Lead terms and modifiers are capitalised and preceded by the appropriate category or code. Together, the category/code, lead term and modifiers form index entries.

Index entries are generally formed using the following standard format;

<b>OPCS-4 Code</b>	<b>Lead Term - Action</b>	<b>Modifier – Site/ subsite</b>	<b>Modifier – Action qualifier(s)</b>
	The action that took place, or the intervention/procedure that was performed	The site/subsite where the action took place, or where the procedure was performed	How the action took place or how the intervention/procedure was done

The lead term and modifiers are listed on one line, rather than listed at separate subdivisions. This means that lead terms and modifiers may be listed multiple times.

The Index also includes the following curtailed terms:

anast.	= anastomosis
endo.	= endoscopic
exam.	= examination
fibreop.	= fibreoptic
prox.	= proximal
recur.	= recurrent
U.G.I.	= upper gastrointestinal

**See also:**

- ***PRule 8 Surgical eponyms***
- ***PRule 9: Surgical abbreviations***
- ***PConvention 1: Cross references***
- ***PConvention 3: Abbreviations***

**Examples:**

Q39.- Examination Fallopian Tube Endoscopic Percutaneous

Here the lead term (action) is 'Examination' the site/subsite modifier is 'Fallopian Tube' and the action qualifiers are 'Endoscopic Percutaneous'

K57.4 Ablation Accessory Pathway Transluminal Percutaneous  
K62.2 Ablation Atrial Wall Atrial Flutter Transluminal Percutaneous  
K57.5 Ablation Atrial Wall Transluminal Percutaneous NEC

The lead term of 'Ablation' is listed multiple times as there are multiple codes that classify ablation procedures.

G45.- Biopsy Duodenum Prox. & Examination G.I. Tract Upper Endo. Fibreoptic

This Index entry includes the curtailed terms Prox. for proximal, G.I for Gastrointestinal, and Endo. for endoscopic.

## GENERAL CODING STANDARDS AND GUIDANCE

### PGCS1: Endoscopic and percutaneous endoscopic procedures that do not have a specific code

When an endoscopic or percutaneous endoscopic procedure is undertaken but no specific code exists to capture this type of approach, the following codes and sequencing are required:

- Open procedure code
- **Y74–Y76** percutaneous endoscopic approach code or **Y85** endoscopic approach
  - When more than one 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)

See also **PCSY6: Approach to organ (Y45–Y52, and Y74-Y77, Y79 and Y85)**

The Tabular List contains categories that distinguish between endoscopic and percutaneous endoscopic procedures to ensure that procedures that can be performed via either route can be easily identified in the classification to allow for accurate data collection and analysis and appropriate reimbursement.

Endoscopic approach refers to a technique using a scope inserted via a natural orifice (nostrils, mouth, anus, urethra, vagina) or an artificial orifice (stoma sites), without requiring a separate skin incision. Examples include bronchoscopy, colonoscopy, cystoscopy, gastroscopy, hysteroscopy, and urethroscopy.

Percutaneous endoscopic approach refers to a technique using a scope inserted through skin incisions for visualisation and intervention within a body cavity or organ. Examples include arthroscopy, laparoscopy and mediastinoscopy.

This naming convention is consistent across all body system chapters even when only one approach is possible.

#### Examples:

*Endonasal endoscopic dacryocystorhinostomy*

**C25.4 Dacryocystorhinostomy NEC**

**Y85.3 Endonasal endoscopic approach to organ**

*Arthroscopic 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 excision of endometriosis of pouch of Douglas.*

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

*Thoracoscopic robotic-assisted coronary artery bypass graft (CABG) of one coronary artery*

- K43.1 Prosthetic replacement of one coronary artery**
- Y74.3 Robotic assisted thoracoscopic approach to thoracic cavity**

## 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 as indicated by notes in the OPCS-4 tabular list, or at specific coding standards.

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 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 are:

- **PCSH6: Colonoscopy and flexible sigmoidoscopy (H20-H25, H38 and H39)**
- **PCSJ2: Failed or abandoned endoscopic retrograde cholangiopancreatography (J43.9).**

#### Examples:

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

#### **G16.9 Unspecified diagnostic fiberoptic 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 percutaneous endoscopic and percutaneous transluminal procedures converted to open (Y71.4, Y71.5, Y72.1 and Y72.2)

When a percutaneous endoscopic 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
- An appropriate failed approach code from:
  - **Y71.4 Failed percutaneous endoscopic approach converted to open NEC**, or
  - **Y71.5 Failed percutaneous transluminal approach converted to open**, or
  - **Y72.1 Failed robotic assisted percutaneous endoscopic approach converted to open**, or
  - **Y72.2 Failed video-assisted percutaneous endoscopic approach converted to open**

#### Examples:

*Failed laparoscopic cholecystectomy, converted to an open cholecystectomy*

**J18.3 Total cholecystectomy NEC**

*Includes: Cholecystectomy NEC*

**Y71.4 Failed percutaneous endoscopic 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.

See also *PCSY6: Approach to organ (Y45–Y52, and Y74-Y77, Y79 and Y85)*

**Examples:**

*Laparotomy with excision of cyst of left ovary*

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

*Right primary total hip replacement (THR) using cement, performed through a 25cm skin incision*

- W37.1 Primary total prosthetic replacement of hip joint using cement**
- Z94.2 Right 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 biopsies have been taken from different sites (with a different site code), assign a site code for each site.

### **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(s) (for the site(s) 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 a 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 or more of these procedures is an excision, the biopsy/biopsies must only be coded if performed on a different site(s) to the excision(s).

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 fiberoptic (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 fiberoptic category.

### Examples:

#### *Endoscopic examination of gastrointestinal tract to pylorus*

##### **G45.9 Unspecified diagnostic fiberoptic 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 fiberoptic 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*

**Z27.1 Oesophagus**

**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 during colonoscopy**

*Includes: 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 during flexible sigmoidoscopy**

*Includes: Descending colon  
Sigmoid 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 during colonoscopy**

*Includes:*

*Large Intestine*

*Rectum*

**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**

*Colonoscopy with submucosal resection and cauterisation of lesions of transverse colon performed at the same time*

**H20.5 Fibreoptic endoscopic submucosal resection of lesion of colon during colonoscopy**

*Includes:*

*Large Intestine*

*Rectum*

**Note:** *Use a subsidiary site code as necessary*

**Z28.4 Transverse colon**

**H20.2 Fibreoptic endoscopic cauterisation of lesion of colon during colonoscopy**

**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 Fiberoptic endoscopic cauterisation of lesion of colon during colonoscopy**

*Includes:*

*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 Fiberoptic endoscopic submucosal resection of lesion of colon during colonoscopy**

**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 1<sup>st</sup> 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 and bone

Grafts (other than skin grafts and bone grafts classified in Chapter W) 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.

### See also:

- **PCSS3: Coding skin grafts and harvests**
- **PChW4: Coding bone grafts**

- **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**

*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**

*Bypass of one coronary artery using saphenous vein graft*

- K40.1 Saphenous vein graft replacement of one coronary artery**

*Myringoplasty of left ear using prosthetic graft*

- D14.1 Tympanoplasty using graft**
- 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**

**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)**

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 fiberoptic coagulation of a bleeding lesion in the oesophagus using haemostatic spray*

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

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

**G42.1 Fiberoptic endoscopic submucosal resection of lesion of upper gastrointestinal tract**

**Z27.2 Stomach**

### **PGCS21: Incision and drainage procedures**

Where an incision is made for the purpose of drainage this must be classified to a drainage code.

Where there is no drainage code available, a **.8 Other specified** code from a category that describes the organ or structure which is being drained must be assigned with a subsidiary code from **Y22.- Drainage of organ NOC**.

**See also PRule4: Category and code structure.**

Where incision and drainage (I&D) is performed the incision is implicit in the drainage.

#### **Examples:**

*Incision and drainage of mouth lesion*

**F42.8 Other specified other operations on mouth**

**Y22.9 Unspecified drainage of organ NOC**

*Drainage of left external ear haematoma*

**D04.1 Drainage of haematoma of external ear**

**Z94.3 Left sided operation**

## PGCS22: Attention to procedures

Where a specific code does not exist classifying the type of attention performed during a procedure, an 'attention to' code (from Chapters A-X) must be assigned.

A supplementary code from Chapter Y must be assigned in addition where it provides additional information about the type of attention.

Where flushing of a prosthesis is performed concurrently with either the insertion or renewal of a prosthesis, the flushing must not be coded in addition.

Programming or re-programming of devices must not be coded when performed concurrently with the insertion, renewal or implantation of a device.

In the absence of a specific code for the type of attention, attention to a prosthesis includes:

- Maintenance including:
  - Refilling of prosthesis, for example pumps
  - Flushing of prosthesis, for example catheters
  - Programming and re-programming of previously implanted device(s)
- Adjustment
- Correction
- Conversion
- Removal
- Renewal
- Revision
- Re-siting

### Examples:

*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**

*Replacement of brain neurostimulator battery*

**A09.2 Attention to brain neurostimulator generator**  
**Y03.2 Renewal of prosthesis in organ NOC**

*Reprogramming of spinal cord neurostimulator*

**A48.5 Reprogramming of spinal cord neurostimulator**

*Insertion and flushing of a central venous catheter*

**L91.2 Insertion of central venous catheter NEC**

*Renewal of cerebroventricular shunt*

**A14.1 Renewal of cerebroventricular shunt**

**PGCS23: Coding endoscopic ultrasound (EUS) procedures**

**Diagnostic Endoscopic Ultrasound (EUS)**

Site codes are not required when an EUS examination without biopsy has been performed. This is an exception to **PGCS10: Coding endoscopic procedures**.

Where a biopsy has been taken and the specific site of the biopsy is not stated in the code description, for example **J79.1 Endoscopic ultrasound examination of hepatopancreatobiliary system and biopsy of lesion of hepatopancreatobiliary system**, a site code must be assigned to identify the site of the biopsy. Where biopsies have been taken from different sites, (with a different site code), assign a site code for each site.

A code(s) from **T86 Sampling of lymph nodes** or **T87 Excision or biopsy of lymph node**, followed by **Y85.4 Endoscopic ultrasonic approach to organ**, must be assigned in addition to the EUS code where lymph nodes are sampled or biopsied during an EUS.

**Y20.4 Fine needle aspiration NOC** must be assigned in addition to the EUS code and/or the lymph node sampling/biopsy code when a fine needle aspiration (FNA) is performed.

**Y41.2 Endoscopic ultrasound staging examination of organ NOC** must be assigned in addition when an EUS is performed as a staging examination.

**Y41.3 Endoscopic ultrasound examination of organ NOC** must only be used, in addition to a body system code, in circumstances where a specific EUS code does not exist.

**Diagnostic EUS of hepatopancreatobiliary system (J79) with upper gastrointestinal endoscopy**

Where an upper gastrointestinal endoscopy is performed prior to an EUS of the hepatopancreatobiliary system, or a biopsy is taken of the gastrointestinal tract with the EUS scope, a code from **G45 Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract** must also be assigned in addition to a code from category **J79 Diagnostic endoscopic ultrasound examination of hepatopancreatobiliary system**.

## **Therapeutic EUS**

Where a therapeutic procedure has been performed using EUS, **Y85.4 Endoscopic ultrasonic approach to organ** must be assigned directly after the body system code for the procedure performed.

### **See also:**

- **PGCS10: Coding endoscopic procedures**
- **PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)**
- **PCSY7: Approach to organ under image control (Y53, Y68 and Y78)**

FNA generally refers to the use of very thin needles to obtain samples of cells or fluid from a suspicious mass. In the context of EUS-guided aspiration, commonly used needle gauges include 19G, 22G, and 25G. While 19G is a larger "fine needle" often used for obtaining core biopsies (fine needle biopsies (FNB)) that yield more tissue for histology, both 22G and 25G needles are referred to as fine needles and are widely used for FNA procedures.

### **Examples:**

*Radial endobronchial ultrasound (EBUS) of the left lung*

**E58.9 Unspecified diagnostic endobronchial ultrasound examination of lung**  
**Z94.3 Left sided operation**

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

**E68.3 Endobronchial ultrasound examination of mediastinum**  
**T87.4 Excision or biopsy of mediastinal lymph node**  
**Y85.4 Endoscopic ultrasonic approach to organ**  
**Y20.4 Fine needle aspiration NOC**

*EUS of oesophagus: the report stated that EUS-FNA was undertaken for the staging of a newly diagnosed oesophageal adenocarcinoma*

**G16.4 Diagnostic fiberoptic endoscopic ultrasound examination of oesophagus and biopsy of lesion of oesophagus**  
**Y20.4 Fine needle aspiration NOC**  
**Y41.2 Endoscopic ultrasound staging examination of organ NOC**

*EUS of upper GI tract: the report stated that there were a large number of well demarcated lymph nodes in the mediastinum. A core biopsy was taken along with a fine needle aspirate of the mediastinal lymph nodes. The EUS did not pass beyond the oesophagus*

- G16.2 Diagnostic fibroptic endoscopic ultrasound examination of oesophagus**
- T87.4 Excision or biopsy of mediastinal lymph node**
- Y85.4 Endoscopic ultrasonic approach to organ**
- Y20.4 Fine needle aspiration NOC**

*EUS of hepatobiliary system: the report stated that a duodenal biopsy had been taken to rule out coeliac disease, further examination showed normal appearance of the pancreas and no common bile duct stones were noted*

- G45.1 Fibroptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract**
- Z27.4 Duodenum**
- J79.9 Unspecified diagnostic endoscopic ultrasound examination of hepatopancreatobiliary system**

*Note: It is not necessary to code additionally any mention of sites examined*

*EUS of hepatobiliary system: the report stated that a fluid sample was obtained from a pancreatic cyst using a 25G needle (responsible consultant confirmed fine needle aspiration). The common bile duct appeared normal and there were no liver lesions*

- J79.1 Endoscopic ultrasound examination of hepatopancreatobiliary system and biopsy of lesion of hepatopancreatobiliary system**  
*Note: Use a subsidiary site code to identify the site of biopsy (Z30, Z31)*
- Y20.4 Fine needle aspiration NOC**
- Z31.1 Pancreas**

*EUS-guided pancreatic necrosectomy*

- J57.6 Pancreatic necrosectomy**
- Y85.4 Endoscopic ultrasonic approach to organ**

### 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–U18, U20-U21, U35–U37 and U42)**

### 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 (X57, X65, X67–X69)**.

### Approach to organ (Y45–Y52, Y74-Y77, Y79 and Y85)

**See PCSY6: Approach to organ (Y45–Y52, Y74-Y77, Y79 and Y85)**

### 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)

### Chapter standards and guidance

**O48.2 Awake brain surgery**, commonly referred to as ‘awake craniotomy’, is assigned in addition to codes from Chapter A Nervous system when surgery on the brain is conducted whilst the patient is awake.

### Coding standards and guidance

Pain relief procedures are classified in OPCS-4 according to whether they are destructive or non-destructive treatments. The term ‘nerve block’ may be used to describe both of these types of procedure. However, it is the method used, i.e. whether the nerve block is destructive or non-destructive that determines code assignment. 

Both destructive pain relief procedures which destroy or damage the nerve and non-destructive pain relief procedures which block or modulate nerve signals without causing permanent damage to the nerve are performed to achieve long term pain relief.

Where there is any uncertainty whether or not the procedure performed is destructive, clarification should be sought from the responsible consultant.

Examples of destructive pain relief treatments include the use of some chemicals, injection of a neurolytic substance, radiofrequency ablation, cryotherapy, denervation and use of a cryoprobe.

Examples of non-destructive pain relief treatments include nerve root blocks, pulsed radiofrequency and therapeutic nerve injections usually involving an anaesthetic and a steroid.

## 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 (X57, X65, X67–X69)**

**A10.7** is required to ensure these procedures are grouped into the correct Healthcare Resource Group (HRG).

### Example:

*Stereotactic radiosurgery using hypofractionated megavoltage stereotactic treatment for trigeminal neuralgia*

**A10.7 Stereotactic radiosurgery on tissue of brain**

*Note: Use an additional code to specify radiotherapy delivery (X69.6)*

**X69.6 Delivery of a fraction of stereotactic external beam radiotherapy**

*Note: Use a subsidiary code to identify external beam radiotherapy (Y91)*

**Y91.5 Megavoltage treatment for hypofractionated stereotactic 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.- Burr hole 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.

### PCSA10: Cranial nerve neurostimulators (A33)



When a complete cranial nerve neurostimulator system is permanently implanted, the following codes and sequencing must be applied:

**A33.1 Implantation of cranial nerve neurostimulator**

Chapter Z site code, where this adds additional information

**Z94.- Laterality of operation** (if applicable)

**A33.3 Removal of cranial nerve neurostimulator** must only be assigned where the complete cranial nerve neurostimulator system is removed.

A complete neurostimulator system consists of a generator/battery, electrodes and leads/wires.

### PCSA9: Spinal and peripheral nerve neurostimulators (A46, A48, A70, A72)



When a spinal or peripheral nerve neurostimulator is permanently implanted, under the skin, the following codes and sequencing are applied:

**A48.3 Implantation of spinal cord neurostimulator** or **A70.1 Implantation of peripheral nerve 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:

**A48.7 Insertion of neurostimulator electrodes adjacent to the spinal cord** or  
**A70.4 Insertion of neurostimulator electrodes adjacent to peripheral nerve**

**Y70.5 Temporary operations**

Chapter Z site code, where this adds further information

**Z94.- Laterality of operation** (if applicable)

Spinal and peripheral nerve neurostimulators often involve a trial insertion of neurostimulator electrodes to ensure effectiveness of the treatment before permanent implantation takes place.

**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**

**PCSA11: Nerve root excision (A58.2, A58.3)**

When more than one spinal nerve root has been excised, **A58.3 Excision of multiple spinal nerve roots** must be assigned, this includes:

- Multiple excisions at different levels of spine
- Bilateral nerve root excisions at the same level.

**A58.2 Excision of single spinal nerve root** must only be used when a single spinal nerve root has been excised (irrespective of level of spine).

**See PCSX34: Pelvic exenteration**

The excision of spinal nerve roots is sometimes performed as part of pelvic exenteration surgery, often alongside sacrectomy, excision of the obturator nerve and/or sciatic nerve. This is usually limited to the sacral nerve roots but may involve lumbar nerve roots in more complex procedures.

**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.

Code **A84.7 Sleep studies NEC** includes a '*full polysomnography*'. A full polysomnography will include electroencephalography (EEG), electrooculography (EOG), and surface electromyography (EMG). Some patients may go on to have a Maintenance of wakefulness test (MWT) (**U33.4**) or Multiple sleep latency test (MSLT) (**U33.5**).

These sleep studies are carried out by specialists in Neurosciences or Sleep Medicine and the emphasis will be on the diagnosis of sleep disorders 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 endoscopic endonasal 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

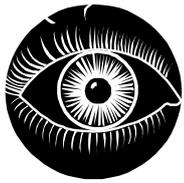
- Y85.3 Endonasal endoscopic approach to organ**
- E15.8 Other specified operations on sphenoid sinus**
- Y85.3 Endonasal endoscopic approach to organ**
- Y26.1 Reconstruction of organ NOC**
- S28.2 Nasoseptal flap**
- Y85.3 Endonasal endoscopic approach to organ**

**See PGCS1: Endoscopic and percutaneous endoscopic procedures 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.

The Neurosurgery Expert Working Group has confirmed that a trans sphenoidal approach involves the opening of the nasoseptal area using an endoscope to allow access. It does not involve the opening of the cranium (craniotomy)

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.



## CHAPTER C EYE (C01–C92)

### Chapter standards and guidance

#### PChSC1: Minimally invasive glaucoma surgery (MIGS)



When a procedure is documented as a MIGS procedure **Y77.3 Minimally invasive approach to organ** must be assigned following the appropriate code for the procedure performed.

**See also PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)**

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**
- Y77.3 Minimally invasive approach to organ**
- 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 (X57, X65, X67–X69)**
- **PCSY10: Anaesthetic (Y80–Y84).**

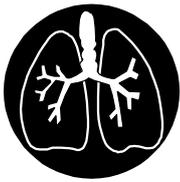


## CHAPTER D EAR (D01–D28)

### 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**.

#### PCSE4: Non operations on lower respiratory tract (E85–E98)



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**, see **PCSE7: Ventilation support (E85) and ventilation initiation (E96)**.

#### PCSE7: Ventilation support (E85) and ventilation initiation (E96)



A code from category **E85 Ventilation support** must be assigned when ventilation support is performed in either an inpatient or outpatient setting. The exception is where ventilation support is performed as part of an initiation episode for long term ventilation where only a code from **E96 Ventilation initiation** must be assigned.

Ventilation initiation (**E96**) is carried out on patients for the purpose of achieving long term ventilation and will include a period of ventilation support.

#### Examples:

*Patient diagnosed with obstructive sleep apnoea (OSA) admitted for planned continuous positive airway pressure (CPAP) initiation*

##### **E96.1 Continuous positive airway pressure initiation**

*Patient with chronic obstructive pulmonary disease admitted with pneumonia with worsening oxygen levels started on CPAP*

##### **E85.6 Continuous positive airway pressure**

### **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.- Exteriorisation of trachea**

Adult patients in an Intensive Care Unit may have a temporary tracheostomy inserted for invasive ventilation but this would be very unusual in children.

A permanent tracheostomy (inserted as a surgical procedure) is typically created as part of the pathway for a child entering a home long-term invasive ventilation pathway (i.e. a child who is ventilator/respirator dependent).



## CHAPTER G UPPER DIGESTIVE TRACT (G01–G84)

### 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 PGCS23: Coding endoscopic ultrasound (EUS) procedures for the standards for coding an endoscopic ultrasound examination (EUS) performed as a staging examination.***



## CHAPTER H LOWER DIGESTIVE TRACT (H01–H74)

### 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

#### PCSH6: Colonoscopy and flexible sigmoidoscopy (H20-H25, H38 and H39)

When coding colonoscopy and flexible sigmoidoscopy procedures, a code from **H20-H25, H38** or **H39** must be assigned based on the procedure documented, rather than the site of the colon reached.

- If a colonoscopy is documented, the procedure must be coded as a colonoscopy (**H20-H22, H38**), even if the examination is limited to the rectum, sigmoid or descending colon. This is an exception to **PGCS3: Incomplete, unfinished, abandoned and failed procedures.**
- If a sigmoidoscopy is documented, the procedure must be coded as a sigmoidoscopy (**H23-H25, H39**), even if the examination extends past the sigmoid colon.

Where there is doubt as to whether a colonoscopy or sigmoidoscopy has been performed, clarification must be sought from the responsible consultant.

**See also:**

- **PGCS10: Coding endoscopic procedures**
- **PCSH2: Colonoscopy with ileal intubation (H22.1)**

The distinction between a sigmoidoscopy and a colonoscopy relates to the extent of the large intestine (colon) examined and, consequently, the bowel preparation required.

A colonoscopy is a more comprehensive procedure designed to visualise the entire colon, from the rectum to the terminal ileum. Because a colonoscopy examines the full length of the colon, it requires more extensive bowel preparation to ensure a clear view. This procedure is also typically longer in duration.

A sigmoidoscopy is a more focused examination that only views the lower part of the large intestine (lower bowel), specifically the rectum and the sigmoid colon, and occasionally the descending colon. Due to this limited examination, it requires less extensive bowel preparation and is a shorter procedure.

**Examples:**

*Colonoscopy report: A colonoscope was inserted via the anus to the distal sigmoid colon, insertion confirmed by images and limited by inadequate bowel preparation. Colonoscopy abandoned.*

**H22.9 Unspecified diagnostic endoscopic examination of colon during colonoscopy**  
**Z28.6 Sigmoid colon**

*Colonoscopy report: Bowel cancer screening. The intended extent of the examination was reached; the colon and terminal ileum were normal.*

**H22.9 Unspecified diagnostic endoscopic examination of colon during colonoscopy**  
**Z27.6 Ileum**

*Sigmoidoscopy report: A paediatric colonoscope was inserted via the anus to the sigmoid, insertion limited by faeces. Extensive sigmoid diverticular disease noted and biopsied.*

**H25.1 Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel during flexible sigmoidoscopy**  
**Z28.6 Sigmoid colon**

*Sigmoidoscopy report: Indication for examination - PR bleeding. Normal flexible sigmoidoscopy to the distal descending colon.*

- H25.9 Unspecified diagnostic endoscopic examination of lower bowel during flexible sigmoidoscopy**
- Z28.5 Descending colon**

### 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 fibrooptic endoscopic examination of colon and biopsy of lesion of colon during colonoscopy**
- 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 during flexible sigmoidoscopy**
- Z28.6 Sigmoid colon**

### PCSH5: Video-assisted anal fistula treatment (VAAFT) (H55, H61 and Y85.8)

The following codes must only be assigned when video-assisted anal fistula treatment (VAAFT) has been used to explore the anal fistula tract, and no further procedure is carried out:

- H55.8 Other specified other operations on perianal region**

**Y85.8 Other specified endoscopic approach to organ**  
**Y31.1 Exploration of sinus tract from organ NOC**

If VAAFT proceeds to a therapeutic procedure on the anal fistula, **Y85.8 Other specified endoscopic approach to organ** must be assigned directly after the appropriate code for the anal fistula procedure (**H55 Other operations on perianal region** or **H61 Operations on perianal region**).

**See also:**

- **PGCS2: Diagnostic versus therapeutic procedures**
- **PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)**

VAAFT utilises a fistuloscope for visualisation of the fistula tract on a monitor. A VAAFT procedure is normally performed in two stages (diagnostic and therapeutic). Both these stages are carried out during the same operation:

- In the diagnostic phase, the fistuloscope is inserted into the fistula to locate the internal opening in the anus and to identify any secondary tracts or abscess cavities.
- In the therapeutic phase of the procedure, the fistula tract is cleaned, and the internal opening of the fistula is sealed.



## CHAPTER J OTHER ABDOMINAL ORGANS – PRINCIPALLY DIGESTIVE (J01–J78)

### 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 PGCS23: Coding endoscopic ultrasound (EUS) procedures for the standards for coding an endoscopic ultrasound examination (EUS) performed as a staging examination.**

## 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.

### 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–K79)

### 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 4<sup>th</sup> 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 Y77.4 Transluminal approach to organ through 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 **Y77.4** must be assigned after each open procedure code.

**See also:**

- **PCSY6: Approach to organ (Y45–Y52, Y74-Y77, Y79 and Y85)**
- **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**

**Y77.4 Transluminal approach to organ through vein**

**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**
- Y77.4 Transluminal approach to organ through vein**
- Y79.3 Transluminal approach to organ through femoral artery**
- Y40.3 Balloon dilation of organ NOC**
- Y53.4 Approach to organ under fluoroscopic control**

### **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

### 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**

### PCSK11: Coronary angioplasty using fractional flow reserve



When coronary angioplasty and/or insertion of stent(s) into the coronary artery/arteries are performed using fractional flow reserve (FFR) or pressure wire studies **K51.3**

**Percutaneous transluminal monitoring of pressure of coronary artery** must be coded in addition.

This is an exception to **PGCS2: Diagnostic versus therapeutic procedures**.

#### Examples:

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

**K63.5 Coronary arteriography using single catheter**

*Note: Use a supplementary code for measurement of fractional flow reserve (K51.3)*

**Y53.9 Unspecified approach to organ under image control**

**K51.3 Percutaneous transluminal monitoring of pressure of coronary artery**

**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**

**Y53.4 Approach to organ under fluoroscopic control**

**K51.3 Percutaneous transluminal monitoring of pressure of coronary artery**

**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 (K70.-, K73.- and K74.-)**



The renewal of a pacemaker generator/battery must be coded to a specific renewal of pacemaker code from **K70.- Leadless cardiac pacemaker system introduced through vein**, **K73.- Other cardiac pacemaker system introduced through vein** or **K74.- Cardiac pacemaker system**, when the type of pacemaker is known.

**K60.3 Renewal of intravenous cardiac pacemaker system NEC** and **K61.3 Renewal of cardiac pacemaker system NEC** must only 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, a code from categories **K70.-**, **K73.-** and **K74.-** must be used as there is a significant resource difference between these renewal procedures.

**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, O54, O56)

### 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**.

#### 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/repared and the individual segments are classifiable to different four character codes, each segment replaced/repared 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**.

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.

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



### Operations on varicose perforator veins

Varicose vein codes that are specific to the saphenous vein must not be used to classify procedures on varicose perforator veins. A non-site-specific code must be used instead, with the site code **Z98.8 Specified vein of lower limb NEC**.

When concurrent procedures are performed on the leg perforator vein(s), they must be coded in addition to the procedures on the saphenous vein(s).

### Combined operations on varicose veins

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.

The following codes must be assigned when any combination of ligation, stripping or avulsion of the leg perforator veins, described in **L85** and **L87**, are performed at the same time:

- L84.8 Other specified combined operations on varicose vein of leg**
- Z98.8 Other specified vein of lower limb**
- Z94.- Laterality of operation**

### Example:

*Stripping and avulsion of right recurrent long saphenous vein with ligation of right perforator veins*

- L84.4 Combined operations on recurrent long saphenous vein**
- L85.8 Other specified ligation of varicose vein of leg**
- Z98.8 Other specified vein of lower limb**
- Z94.2 Right sided operation**

*Ultrasound guided foam sclerotherapy to long saphenous varicose vein and perforator veins left leg*

- L86.2** Ultrasound guided foam sclerotherapy for varicose vein of leg
- Z98.5** Long saphenous vein
- Z98.8** Specified vein of lower limb NEC
- Z94.3** Left 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.



## CHAPTER M URINARY (M01–M92)

### 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

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.

### 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 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**

*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**

*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, Y74–Y77, Y79 and Y85)**
- **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**



## CHAPTER P LOWER FEMALE GENITAL TRACT (P01–P33)

### 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

#### PCSP3: Episiotomy to facilitate delivery of terminated pregnancy or late miscarriage and subsequent repair (P14.9, P13.2, P25.5)

Where an episiotomy (**P14.9 Unspecified incision of introitus of vagina**) is carried out to facilitate delivery of a terminated pregnancy, or late miscarriage, this must be sequenced in a secondary position to the delivery code (**Q58 Delivery of terminated pregnancy** or **Q59 Delivery of late miscarriage**).

The subsequent repair of an episiotomy is included within code **P14.9** 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 pregnancy (Q58), or late miscarriage (Q59)**

**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 \(www.gov.uk\)](http://www.gov.uk) for more information.



## CHAPTER Q UPPER FEMALE GENITAL TRACT (Q01–Q63)

### 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

#### PCSQ5: Genital swab (Q55.6)

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

The codes in category **Q58 Delivery of terminated pregnancy** and **Q59 Delivery of late miscarriage** are for use when it is documented in the medical record that the responsible consultant (for example a midwife) has ‘delivered’ a fetus following a medically terminated pregnancy (which may be liveborn or showing no signs of life), or a late miscarriage. The delivery of a terminated fetus is generally performed for late termination of pregnancy.

A late miscarriage is a spontaneous loss of pregnancy from 13 up to and including 23+6 weeks gestation.

It is strongly recommended that coding managers work closely with the responsible consultants to ensure codes in category **Q58** and **Q59** are assigned when appropriate.

**Examples:**

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

**Q58.1 Cephalic delivery of terminated pregnancy**

**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**

*Patient admitted for a medically induced (prostaglandin pessary) termination of pregnancy at 16 weeks gestation. The fetus was delivered (in breech position) by the consultant.*

**Q58.2 Breech delivery of terminated pregnancy**

**Y95.2 From 14 weeks to 20 weeks gestational age**

**Q14.5 Insertion of prostaglandin pessary**

**Y95.2 From 14 weeks to 20 weeks gestational age**

*Patient admitted with spontaneous miscarriage at 13+2 weeks gestation. The fetus was delivered (in cephalic position) without complication.*

**Q59.1 Cephalic delivery of late miscarriage**

**Y95.3 From 9 weeks to < 14 weeks gestational age**



## CHAPTER R FEMALE GENITAL TRACT ASSOCIATED WITH PREGNANCY, CHILDBIRTH AND PUERPERIUM (R01–R44)

### Chapter standards and guidance

#### 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**) or late miscarriage (**Q59**)), 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) or late miscarriage (Q59).**

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**

*Normal vaginal delivery of stillbirth at 25 weeks gestation*

**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

### 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 pregnancy or late miscarriage 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 only be used in an outpatient setting or 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–U18, U20-U21, U35–U37 and U42).**

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 and bone**
- **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:

*Debridement and primary suture of laceration of scalp.*

- 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.



## CHAPTER T SOFT TISSUE (T01–T98)

### Chapter standards and guidance

#### Endoscopic ultrasound staging examination

**See PGCS23: Coding endoscopic ultrasound (EUS) procedures for the standards for coding an endoscopic ultrasound examination (EUS) performed as a staging examination.**

### Coding standards and guidance

#### PCST4: Anterior abdominal wall reconstruction for hernia repair (T32)



When an abdominal wall hernia (incisional, parastomal or ventral) is repaired using abdominal wall reconstruction (involving some form of myofascial release) a code from **T32 Reconstruction of anterior abdominal wall** must be assigned. A separate hernia repair code must not be assigned in addition.

Where there is any doubt that abdominal wall reconstruction has been performed clarification must be sought from the responsible consultant using the definitions provided in the guidance box.

If mesh and/or scaffold has been used a code from **Y28 Insertion of other material into organ NOC** and/or **Y36 Introduction of non-removable material into organ NOC** must be assigned in addition to the code from **T32**.

Where there is any doubt regarding the type of mesh or scaffold that has been used clarification must be sought from the responsible consultant.

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

Myofascial release in abdominal wall reconstruction refers to surgical techniques that free or divide specific layers of the abdominal wall musculofascial system to allow tension-free closure of large midline defects.

The following procedures are considered forms of myofascial release and are an indication of abdominal wall reconstruction:

- Rives-Stoppa

- Anterior Component Separation (ACS)
- Transversus Abdominis Release (TAR)
- Posterior Component Separation (PCS)

Other indications of abdominal wall reconstruction within the operation note include, but are not limited to:

- Retrorectus mesh
- Retromuscular mesh

An abdominal hernia repair would **not** be classified as abdominal wall reconstruction if it employs techniques that focus on a simple suture repair, bridging the defect or using simpler fascial closure, rather than involving a myofascial release.

### Examples:

*Laparotomy and extensive adhesiolysis. Repair of complex abdominal wall hernia requiring bilateral transverse abdominis release, re-enforced with a synthetic absorbable tissue re-enforcement scaffold and permanent synthetic polyvinylidene fluoride (PVDF) mesh. 2-0 PDS small bites closure with partial anterior fascial apposition. A 5cm fascial gap remained so the fascial edges were sutured to the mesh circumferentially with 2-0 prolene and the peritoneal flap was then secured across to cover the mesh with 2-0 PDS.*

- T32.4 Reconstruction of anterior abdominal wall using insert of prosthetic material and flap NEC**
- Y28.1 Insertion of synthetic mesh into organ NOC**
- Y36.6 Introduction of synthetic scaffold into organ NOC**
- T41.5 Freeing of extensive adhesions of peritoneum**

*Rives-Stoppa repair of incisional hernia with placement of permanent polypropylene mesh in the retrorectus space to provide robust, tension-free reinforcement.*

- T32.2 Reconstruction of anterior abdominal wall using insert of prosthetic material**
- Y28.1 Insertion of synthetic mesh into organ NOC**

*Laparotomy, repair of parastomal hernia and incisional hernia with intraperitoneal onlay mesh (IPOM) using Reinforced Tissue Matrix (RTM). Responsible consultant confirmed this was a biosynthetic tissue re-enforcement scaffold.*

- T25.2 Primary repair of incisional hernia using insert of prosthetic material**
- Y36.7 Introduction of other scaffold into organ NOC**

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) and targeted lymph node dissection (T84.1)

When sampling, excision, biopsy or drainage of sentinel lymph node is performed the following codes must be assigned:

#### **T86-T88**

**Y45.5 Approach to organ under marker guided control NEC**

**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.

When targeted lymph node dissection (**T84.1 Targeted excision of lymph node**) is performed at the same time as a sentinel lymph node biopsy, codes classifying both procedures must be assigned. This is an exception to **PGCS2: Diagnostic versus therapeutic procedures**.

#### **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)*

**Y45.5 Approach to organ under marker guided control NEC**

**Y68.1 Approach to organ under contrast enhanced ultrasonic control**

**O14.2 Sentinel lymph node**

**Z94.2 Right sided operation**

*Targeted axillary dissection (TAD) under marker guided control following sentinel lymph node biopsy of left breast.*

**T84.1 Targeted excision of lymph node**

*Note: Use an additional code to identify concurrent biopsy of sentinel lymph node (T87)*

**Y45.5 Approach to organ under marker guided control NEC**

**Z61.3 Axillary lymph node**

**Z94.3 Left sided operation**

**T87.3 Excision or biopsy of axillary lymph node**

*Note: Use subsidiary code for sentinel lymph node (O14.2)*

**Y45.5 Approach to organ under marker guided control NEC**

**O14.2 Sentinel lymph node**

**Z94.3 Left sided operation**



## CHAPTER U DIAGNOSTIC IMAGING, TESTING AND REHABILITATION (U01–U54)

### Coding standards and guidance

#### PCSU1: Diagnostic imaging procedures (U01–U18, U20–U21, U35–U37 and U42)

##### 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 NEC**, **C87.1 Digital imaging of retina NEC** and scanning codes within the range **R36–R43**, the body system chapter code **must** be used in preference to the diagnostic imaging codes within Chapter U.

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–U18** and **U20–U21** and their extended categories **U35–U37** and **U42** must only be used in an outpatient setting, or when the patient has been admitted solely for the purpose of a diagnostic imaging procedure/intervention. The exceptions to this are:

- **Magnetic Resonance Imaging (MRI)**
- **Computed Tomography (CT)**
- **U17.7 Wireless capsule endoscopy of digestive tract**
- **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 diagnostic imaging codes in Chapter U 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)*.

The diagnostic imaging codes in Chapter U that classify nuclear medicine imaging procedures do not require the addition of codes from categories **Y97** or **Y98** unless there is a note at code level instructing otherwise – **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 are **PCSU8: Cardiac computed tomography for calcium scoring and cardiac computed tomography angiography (U10.2)**, **PCSU9: Bone densitometry (U13.1)** and **PCSU11: Vascular ultrasound scans.**

#### **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.

### 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 diagnostic imaging codes in Chapter U 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 diagnostic imaging codes in Chapter U unless there is a specific instruction to do so – 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 (U01–18, U20–U21, U35–U37 and U42)**

Nuclear medicine imaging codes in Chapter U must only be used in an outpatient setting or when the 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 in Chapter U 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** as indicated by the notes within the tabular list, 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 any other nuclear medicine imaging codes, **see PCSU1**

**Diagnostic imaging procedures (U01–U18, U20–U21, U35–U37 and U42) and PCSU2: Radiological contrast and body areas (Y97-Y98).**

**See also PCSU4: Myocardial/Cardiac perfusion scan (U10.6 and U11.5).**

There are two nuclear medicine imaging procedures available in the main body system chapters. These are **B16.4 Parathyroid washout** and **T91.2 Scanning of sentinel lymph node**.

**Examples:**

*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)  
Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)*

**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–U18, U20-U21, U35–U37 and U42)**.

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)**

### PCSU11: Vascular ultrasound scans

The codes classifying vascular ultrasound must only be used in an outpatient setting or if the patient has been admitted solely for the purpose of a procedure/intervention.

When coding vascular ultrasound scans one of the following codes must be assigned, regardless of the number of body areas scanned, or if performed concurrently with another scan on the same body area:

- U11.1** Ultrasound of carotid artery
- U11.2** Doppler ultrasound of vessels of extremities
- U11.3** Vascular ultrasound NEC
- U35.2** Laser Doppler ultrasound velocimetry
- U35.3** Transcranial Doppler ultrasound velocimetry

**U21.6 Ultrasound scan NEC** must not be used to classify these procedures; the coding of vascular ultrasound scans is an exception to **PCSU1: Diagnostic imaging procedures (U01-U18, U20-U21, U35-U37, U42)**. Vascular ultrasound scans must be coded in addition to other types of scans using one of the codes above.

**See also PCSU2: Radiological contrast and body areas (Y97-Y98).**

#### Example:

*Patient admitted for bilateral carotid artery ultrasound scan (8-minute duration) and CT scan of cerebral vessels with pre and post contrast.*

- U11.1** Ultrasound of carotid artery  
*Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)*
- Y98.1** Radiology of one body area (or < 20 minutes)
- Z94.1** Bilateral operation
- U11.4** Computed tomography scan of cerebral vessels  
*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)

### 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** must only be used 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–U18, U20-U21, U35–U37 and U42)**.

Bone densitometry scan or DEXA scan would never be performed using contrast.

#### Example:

*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 must only be used in an outpatient setting, or when the 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 and classification of epilepsy and non-epileptic attack disorders, and also for the diagnosis of neurological disorders of sleep. EEG telemetry involved continuous recording of EEG over a minimum of 24 hours but can be significantly longer. This can be with or without simultaneous video recording of the patient. **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.

Studies for sleep disorders involving respiratory functions, such as sleep apnoea, are classified at code **U33.1 Polysomnography**. They are normally conducted by a specialist Respiratory team using cardiopulmonary sleep studies which uses 3 or more types of sensors (known as "channels") but without electroencephalography. 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–V71)

### 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 distractors to skull**
- Y70.3 First stage of staged operations NOC**

**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.

**PCSV8: Instrumented lumbar fusion (V40.4)**

When a lumbar interbody fusion procedure has been performed and the fusion is documented as instrumented; code **V40.4 Posterior instrumented fusion of lumbar spine NEC** must not be assigned in addition.

Instrumented lumbar fusion including the use of cages, screws rods and plates is an integral part of a lumbar interbody fusion.

**Example:**

*L4/L5 posterior lumbar interbody fusion using graft and cage with concurrent posterior instrumented fusion of L4/L5 using pedicle screws and rods.*

**V38.5 Primary posterior interbody fusion of joint of lumbar spine**  
**V55.1 One level of spine**

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'.

**PCSV7: Spinal fracture procedures (V44, V45 and V46)**

Where a specific code(s) for a procedure(s) performed for a spinal fracture does not exist within **V44 Decompression of fracture of spine**, **V45 Other reduction of fracture of spine** or **V46 Fixation of fracture of spine** but there is a specific code(s) elsewhere within Chapter V, this code(s) must be assigned instead.

The code(s) assigned must fully and accurately reflect the procedure(s) performed. Where there is any uncertainty regarding the specific procedure(s) carried out, advice must be sought from the responsible consultant

The use of a combination of ICD-10 and non-fracture-specific OPCS-4 codes from Chapter V provides a more comprehensive classification of spinal fracture procedures than relying on **V44**, **V45**, and **V46** alone.

**Examples:**

*Posterior stabilisation of L2 fracture using screws under image intensifier guidance*

**V46.6 Fixation of fracture of spine using screw**  
**V55.1 One level of spine**  
**Y53.5 Approach to organ under image intensifier**  
**Z66.5 Lumbar vertebra**

*Patient with a C5 fracture underwent a primary anterior corpectomy of C5 with reconstruction using cage*

**V22.4 Primary anterior corpectomy of cervical spine with reconstruction HFQ**  
**V55.1 One level of spine**

***See Chapter A for guidance on the classification of pain relief procedures.***



## CHAPTER W OTHER BONES AND JOINTS

(W01–W99, O06–O10, O17–O19, O21–O27, O29, O32, O35, O37–O41, O49, O51, O55)

### 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 percutaneous endoscopic operations on other joint structure** must only be assigned when:

- There is no specific 4<sup>th</sup> character percutaneous endoscopic (arthroscopic) code that classifies the procedure
- There is no specific 4<sup>th</sup> character open code that classifies the procedure
- There is no **.8 Other specified** code in any other percutaneous endoscopic or open category that describes the organ or structure on which the procedure is performed

**See PGCS1: Endoscopic and percutaneous endoscopic procedures 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 Iliizarov fixator, it is the external part of the device that is holding the fracture, and therefore this is coded as an external fixator.

### PChSW4: Coding bone grafts

When a bone graft (of bones other than skull and spine) is performed, a code from **W31 Other autograft of bone**, **O55 Autograft of bone** or **W32 Other graft of bone** must be assigned to classify the type of bone graft. This includes where another body system code already identifies a bone graft or is an HFQ code (this is an exception to **PConvention 3: Abbreviations**).

**Autograft** of bone must be coded as follows:

- **W31 Other autograft of bone** or **O55 Autograft of bone**
- **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 being grafted
- **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 site of the harvest (if this has not already been identified within the Y harvest code)
- **Z94.- Laterality of operation** (if applicable).

The exception to this standard is **PCSW4: Total hip replacement with acetabular bone graft (W37-W39)**, as it may not always be necessary to code an acetabular bone autograft.

### Examples:

*Primary open reduction and internal fixation of left distal radius using plate, bone defect filled using morcellised autograft harvested from left iliac crest.*

**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**  
**W31.4 Cancellous chip autograft of bone**  
**Z70.5 Lower end of radius NEC**  
**Z94.3 Left sided operation**  
**Y66.3 Harvest of bone from iliac crest**  
**Z94.3 Left sided operation**

*Primary fusion of left ankle joint using screws and bone allograft to talus bone*

**W60.1 Primary arthrodesis and extra-articular bone graft NEC**  
**Z85.6 Ankle joint**  
**Z94.3 Left sided operation**  
**W32.2 Allograft of bone NEC**  
**Z79.1 Talus**  
**Z94.3 Left sided operation**

*Curettage of enchondroma of phalanx of right thumb. Bone allograft used to fill the defect*

**W09.5 Curettage of tumour of bone and graft HFQ**  
**Z73.3 Phalanx of thumb**  
**Z94.2 Right sided operation**  
**W32.2 Allograft of bone NEC**  
**Z73.3 Phalanx of thumb**  
**Z94.2 Right sided operation**

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.

**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 2<sup>nd</sup> metatarsal bone with internal fixation and osteotomy of 1<sup>st</sup> 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 1<sup>st</sup> metatarsal bone, internal fixation with two screws and Akin osteotomy of 1<sup>st</sup> 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**

## 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**

#### **PCSW16: Open reduction of fracture of bone and intramedullary fixation (W19)**

The following codes in **W19 Primary open reduction of fracture of bone and intramedullary fixation** must be used if the code description fully describes the procedure performed, even if the type of fixation is **not** 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**
- W19.5 Primary open reduction of fragment of bone and fixation using screw**
- W19.6 Primary open reduction of fragment of bone and fixation using wire system**

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.

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** (which classify procedures that are not considered intramedullary) should continue to be used where the four-character code description reflects the procedure documented within the medical record.

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) and implantation of augmentation prosthesis (O09.2)



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** or **O55.- Autograft 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**

Where a graft augmentation prosthesis is implanted into an acetabular bone defect concurrently with a total hip replacement procedure, the following codes must be assigned in addition:

**O09.2 Implantation of augmentation prosthesis into defect of bone**

**Z75.6 Acetabulum**

**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.

**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 and implantation of a porous augmentation prosthesis into a severe 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**  
**O09.2 Implantation of augmentation prosthesis into defect of bone**  
**Z75.6 Acetabulum**  
**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**

### **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 Percutaneous 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**



## 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 Percutaneous 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 Percutaneous 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**

### **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 Percutaneous 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 Percutaneous 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*

**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**

### **PCSW15: Sacrectomy (O29.2, O29.3, O29.4)**

Excision of part of the sacrum (sacrectomy) must be coded whenever performed. Code assignment will depend on the extent of the sacrum excised, with only the most extensive type of sacrectomy being coded.

**O29.2 High subcortical sacrectomy** (least extensive)

**O29.3 Low sacrectomy**

**O29.4 High sacrectomy** (most extensive)

**See also PCSX34: Pelvic exenteration**

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 of foot 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/tenecteplase.**

### 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).**

## PCSX32: Cytoreductive surgery (X13.1)



**X13.1 Cytoreductive surgery** must be assigned when cytoreductive surgery is documented to have been carried out.

As cytoreductive surgery involves the resection of multiple tissues and organs, codes for these procedures must be assigned following **X13.1**.

### Example:

*Open cytoreductive surgery after neoadjuvant chemotherapy for stage 4 high grade serous ovarian cancer with extensive peritoneal adhesiolysis, en bloc resection of the left ovary and fallopian tube, anterior resection of part of the rectum and sigmoid colon with primary stapled anastomosis. Resections of the posterior peritoneum, omentectomy, incidental appendectomy and resection of lesion from pouch of Douglas.*

#### **X13.1 Cytoreductive surgery**

*Note: Code in addition the specific organ or tissue resection procedures*

#### **Q23.1 Unilateral salpingoophorectomy NEC**

#### **Z94.3 Left sided operation**

#### **H02.4 Incidental appendectomy**

#### **T41.5 Freeing of extensive adhesions of peritoneum**

#### **T41.6 Excision of peritoneum**

#### **T36.1 Omentectomy**

#### **H33.3 Anterior resection of rectum and anastomosis of colon to rectum using staples**

#### **P31.7 Extirpation of lesion of pouch of Douglas**

## PCSX34: Clearance of pelvis (X14)



### **Pelvic exenteration**

A code from **X14.1-X14.3** must only be assigned when pelvic exenteration is documented to have been carried out.

Codes for the associated resection and reconstruction procedures must be assigned in addition; these codes may be sequenced in any order providing they are **all** sequenced following **X14.1-X14.3** and adhere to other National Clinical Coding Standards as appropriate.

### **Pelvic sidewall clearance**

If pelvic side wall clearance is performed in addition to pelvic exenteration, **X14.4 Pelvic side wall clearance** must be coded in addition to **X14.1-X14.3**, in any secondary position.

**X14.4** includes resection of the internal iliac artery and vein. If other veins and/or arteries (such as the common iliac vessels) are resected, these must be coded in addition

**See also:**

- **PCSA11: Nerve root excision (A58.2, A58.3)**
- **PCSW15: Sacrectomy (O29.2, O29.3, O29.4)**

Pelvic exenteration surgery involves the resection and reconstruction of multiple tissues and organs.

**Example:**

*Total pelvic exenteration involving total cystectomy, extra-levator abdominoperineal excision (ELAPE), total abdominal hysterectomy, bilateral salping-oophorectomy, pelvic sidewall clearance and low sacrectomy. Total vaginectomy and further pelvic block dissection of lymph nodes was also performed. End colostomy formation was performed following the ELAPE. Segment of ileum excised for ileal conduit formation. Vaginal reconstruction using pelvic peritoneum and perineal reconstruction using superior gluteal artery perforator flap (SGAP) were used to reapproximate anatomy and close defects.*

- X14.1 Total exenteration of pelvis**
- H45.1 Extralevator abdominoperineal excision of rectum and end colostomy**
- P12.3 Reconstruction of female perineum using gluteal artery perforator flap**
- X14.4 Pelvic side wall clearance**
- O29.3 Low sacrectomy**
- M34.3 Cystectomy NEC**
- M19.1 Construction of ileal conduit**
- Q07.4 Total abdominal hysterectomy NEC**
- Q22.1 Bilateral salpingoophorectomy**
- P17.1 Total colpectomy**
- P32.2 Reconstruction of vagina using pelvic peritoneal graft**
- T85.6 Block dissection of pelvic lymph nodes**

**PCSX33: Gender affirmation procedures (X15)**

Code **X15.1 Combined operations for transformation from male to female** or **X15.2 Combined operations for transformation from female to male** must be assigned whenever gender affirmation procedure(s) have been documented to have been carried out.

Codes from the body system chapters that describe the specific procedure(s) performed must also be assigned and sequenced following **X15.1** or **X15.2**. This includes staged and revision surgery where there may be significant periods of time between procedures, and where only a single procedure has been performed.

**Examples:**

*Bilateral inframammary fold mastectomy and free nipple sharing grafts chest masculinisation (female to male)*

**X15.2 Combined operations for transformation from female to male**  
**B27.4 Total mastectomy NEC**  
**B36.3 Nipple sharing NEC**  
**Z94.1 Bilateral operation**

*Gender affirming total abdominal hysterectomy and bilateral salpingo-oophorectomy (female to male)*

**X15.2 Combined operations for transformation from female to male**  
**Q07.4 Total abdominal hysterectomy NEC**  
**Q22.1 Bilateral salpingoophorectomy**

*Gender affirming bilateral insertion of subcutaneous tissue expanders into breast (male to female) first stage*

**X15.1 Combined operations for transformation from male to female**  
**S48.2 Insertion of skin expander into subcutaneous tissue of breast**  
**Y70.3 First stage of staged operations NOC**  
**Z94.1 Bilateral operation**

*Gender affirming bilateral exchange of tissue expanders to permanent breast implants (male to female) second stage*

**X15.1 Combined operations for transformation from male to female**  
**B30.4 Renewal of prosthesis for breast NEC**  
**Y71.1 Subsequent stage of staged operations NOC**  
**Z94.1 Bilateral operation**

### 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)**.*

### 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 and bone.**

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.

## 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.

## PCSX35: Active cooling and rewarming therapy (X51)

**X51.1 Rewarming therapy** must only be assigned when the patient is treated for hypothermia, it must not be assigned where:

- treatment is given to prevent hypothermia
- rewarming has taken place following active cooling, as this is implicit in the assignment of **X51.2 Active cooling**
- only passive external rewarming has taken place.

**X51.2 Active cooling** must be coded each time it is carried out.

**X51.2** must not be assigned in instances where cooling is focussed on a single body area, for example, the use of cooling caps in chemotherapy patients.

Passive external rewarming allows the patient's own body heat to rewarm them by providing a warm environment and insulating materials like blankets.

Active cooling involves a reduction of the entire body core temperature. It may also be described as 'therapeutic hypothermia' or 'therapeutic cooling' or as 'deep hypothermic

arrest' (DHCA) or 'deep hypothermic arrest with cerebral perfusion' within a cardiac surgery operation note.

### 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 (X57, X65, X67–X69)



### Preparation for radiotherapy

Preparation for radiotherapy is coded as follows:

- X57.- Preparation for other radiotherapy, 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.

The following codes are radionuclide/radioisotope/molecular therapy and do not require the addition of a code from categories **Y35**, **Y36**, **Y89**, **Y91** or **O44**:

- **X65.5 Oral delivery of radiotherapy for thyroid ablation**
- **X65.7 Delivery of radionuclide therapy NEC**
- **X69.3 Oral delivery of radionuclide therapy NEC**

- **X69.4 Intravenous injection delivery of radionuclide therapy**
- **X69.5 Intravenous infusion delivery of radionuclide therapy**

**See also:**

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

A radiotherapy prescription specifies a dose and fractionation (external beam, brachytherapy) for a series of identical treatments. This is similar to a medical prescription. Different anatomical sites treated concurrently by external beam or brachytherapy 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**
  - Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)*
  - 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**
  - Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)*
  - 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**
- X69.6 Delivery of a fraction of stereotactic external beam radiotherapy**
  - Includes: Delivery of a fraction of stereotactic external beam ablative radiotherapy*
  - Note: Use a subsidiary code to identify external beam radiotherapy (Y91)*
- Y91.5 Megavoltage treatment for hypofractionated stereotactic 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**
  - Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)*
  - 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**

*Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)*

*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**

*Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)*

*Note: Use a subsidiary code to identify external beam radiotherapy (Y91)*

**Y91.2 Megavoltage treatment for simple radiotherapy**

**Z75.9 Bone of pelvis NEC**

*Preparation and delivery of Lutetium (Lu-177) radionuclide via intravenous infusion*

**X57.1 Preparation for radionuclide therapy**

*Includes: Preparation for molecular radiotherapy*

**X69.5 Intravenous infusion delivery of radionuclide therapy**

*Includes: Intravenous infusion delivery of molecular radiotherapy*

### **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:**

- ***PRule11: 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 (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 IV 7 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 the patient receiving 3 cycles of FEC 100, once these are completed this is then followed by 3 cycles of Docetaxel 100mg.*

*Day 1, Cycle 1, 2, 3 FEC 100*

**X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance**

*Day 1, Cycle 1, 2, 3 Docetaxel 100mg*

**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:**

- ***PRule11: 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 (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/tenecteplase.*
- **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 in April 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 (X57, 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 (Y12.3)**

***See PCSY14: Electrochemotherapy (Y12.3)***

**PCSX25: Administration of thrombolytic/fibrinolytic drugs and alteplase/tenecteplase**

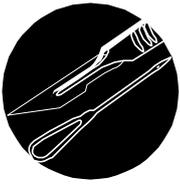
When a thrombolytic/fibrinolytic drug (with the exception of alteplase and tenecteplase for acute stroke) has been administered they must be coded according to the method of administration.

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**

#### 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 and phototherapeutic 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 Percutaneous 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 (Y12.3)

Where electrochemotherapy is performed following delivery of a chemotherapy regimen this must be coded as follows:

Destruction body system chapter code

### **Y12.3 Electrochemotherapy to lesion of organ NOC**

*Includes: Electroporation to lesion of organ with chemotherapy NOC*

Chapter Z site code(s), where this adds further information

**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**
- S11.8 Other specified other destruction of lesion of skin of other site**
- 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 (X57, 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. Subcutaneous 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**
- Y69.8 Other specified harvest of other tissue**
- 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.

#### PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)



Where a method of approach classifiable to categories **Y45–Y52, Y74–Y77, Y79** and **Y85** is not incorporated within the body system code description, a code from these categories must be assigned directly after the body system code. This does not apply to **Y48.- Approach to spine through back, Y49.3 Thoracotomy approach NEC** and **Y50.2 Laparotomy approach NEC** (except when coding the removal of vaginal or transobturator tape using codes in categories **M53** and **M57** as per **PCSM11: Removal of vaginal and transobturator tape (M53 and M57)**), as these codes are not required for open spinal, thoracic or abdominal surgery when the laminectomy/incisions are the only means of approach in order to access the procedure site. See also **PGCS8: Incision as a means of approach**.

Where a number of procedures have taken place using the same or different methods of approach a code from categories **Y45–Y52, Y74–Y77, Y79** and **Y85** must be assigned directly after each body system code.

When a code from one of the following categories is used to supplement a body system code, the approach code from categories **Y45–Y52, Y74–Y77, Y79** and **Y85** must be assigned directly after the supplementary code:

- **L76.- Endovascular placement of stent**
- **L89.- Other endovascular placement of stent**
- **O20.- Endovascular placement of stent graft**
- **V55.- Levels of spine**

**Procedures performed by percutaneous endoscopic approach**

Codes that state ‘percutaneous endoscopic’ in the code description do not require an approach code from **Y74-Y76**, unless the approach code provides additional detail about the type of approach, e.g., **Y75.3 Robotic assisted laparoscopic approach to abdominal cavity**.

**See also:**

- **PGCS1: Endoscopic and percutaneous endoscopic procedures that do not have a specific code**
- **PGCS8: Incision as a means of approach**
- **PChSK1: Percutaneous transluminal operations that do not have a specific code**
- **PCSY16: Minimally invasive approach (Y77.3)**

For open spinal, thoracic, and abdominal surgery, the laminectomy/incision for access is considered an inherent component of the procedure. Coding these methods of access separately would create redundant data, inflate perceived procedural complexity, and not accurately reflect distinct clinical interventions or resource consumption.

In contrast, approaches to the brain (**Y46 Open approach to contents of cranium** and **Y47 Burr hole approach to contents of cranium**) represent significantly more complex and resource-intensive procedures in their own right. These involve intricate anatomical considerations, specialised equipment and prolonged theatre time, and carry unique risks and potential complications distinct from the subsequent intracranial procedure.

There is no sequencing instruction when assigning multiple codes from **Y45–Y52, Y74-Y77, Y79** and **Y85**.

**Examples:**

*Open biopsy of lesion of frontal region of brain through frontal burrhole*

**A08.1 Biopsy of lesion of tissue of frontal lobe of brain NEC**  
**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**  
**Y85.1 Functional endoscopic sinus surgery**

*Laparotomy with excision of cyst of left ovary*

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

*Laparoscopic total abdominal hysterectomy and bilateral salpingoophorectomy*

- 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

*Hysteroscopic microwave endometrial ablation*

- Q17.6** Endoscopic microwave ablation of endometrium

*Arthroscopic adhesiolysis of left temporomandibular joint*

- V64.3** Percutaneous endoscopic release of temporomandibular joint
- Z94.3** Left sided operation

*Laparoscopic-assisted percutaneous endoscopic gastrostomy (LAPEG)*

- G44.5** Fibreoptic endoscopic percutaneous insertion of gastrostomy
- Y75.1** Laparoscopically assisted approach to abdominal cavity

*Laparoscopic-assisted laser excision of ovarian cyst*

- Q49.1** Percutaneous endoscopic extirpation of lesion of ovary NEC
- Y75.1** Laparoscopically assisted approach to abdominal cavity
- Y08.2** Laser excision of lesion of organ NOC

**PCSY17: Robotic approach to organ and body cavity (Y45.2, Y74.3, Y75.3, Y76.5 and Y85.5)**

When a procedure has been performed using robotic assistance, code assignment is dependent on the method of approach.

**Percutaneous endoscopic approach**

Assign one of the following codes when the robotic system utilises an endoscope and the procedure is performed endoscopically via minimal incisions. Code assignment is based on the approach e.g., thoracoscopic, laparoscopic, arthroscopic

- **Y74.3 Robotic assisted thoracoscopic approach to thoracic cavity**
- **Y75.3 Robotic assisted laparoscopic approach to abdominal cavity**
- **Y76.5 Robotic assisted percutaneous endoscopic approach to other body cavity**

### **Endoscopic approach**

Assign **Y85.5 Robotic assisted endoscopic approach to organ** when the robotic system utilises an endoscope and the procedure is performed endoscopically via a natural orifice, e.g. via the urethra or mouth

### **Non-endoscopic approach**

Assign **Y45.2 Robotic assisted approach to organ NEC** when the surgeon has direct visualisation of the surgical site and the robotic system does not utilise an endoscope.

Where there is doubt as to whether the robot utilises an endoscope, clarification must be sought from the responsible consultant.

Many robotic assisted procedures involve a surgeon sitting at a remote console and viewing the surgical site through an endoscopic camera. The endoscope sends a high definition, magnified 3D view of the surgical site to a console where the surgeon is seated. The surgeon controls the robotic arms from the console with their hand movements. An example of this type of robot is the da Vinci Surgical System; widely used in laparoscopic and cardiothoracic surgery, as well as transoral surgery to treat hard to reach areas like the back of the throat, tonsils, or base of the tongue.

Robotic assisted procedures that do not utilise an endoscope typically involve the surgeon standing at the operating table, directly viewing the patient, and controlling robotic arms to guide their surgical instruments based on a pre-operative 3D plan. These types of robotics tend to be used in orthopaedic, spinal and neurosurgery. An example of this type of robot is the Mako SmartRobotics, primarily used for hip and knee replacements.

### **Examples:**

*Robotic-assisted laparoscopic kidney transplant from live donor*

**M01.2 Allotransplantation of kidney from live donor**

**Y75.3 Robotic assisted laparoscopic approach to abdominal cavity**

*Transurethral water-jet ablation of prostate using robotic handpiece with integrated cystoscopy. A transrectal ultrasound (TRUS) probe was inserted into the rectum to provide real-time high-resolution imaging of the prostate.*

- M65.7 Endoscopic ablation of prostate using waterjet**
- Y85.5 Robotic assisted endoscopic approach to organ**
- Y53.2 Approach to organ under ultrasonic control**

*Robotic-assisted primary total hip replacement using cement*

- W37.1 Primary total prosthetic replacement of hip joint using cement**
- Y45.2 Robotic assisted approach to organ NEC**

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

Where the type of image control classifiable to categories **Y53**, **Y68** and **Y78** is not incorporated within the body system code description, a code from these categories must be assigned directly after the code(s) for the procedure (i.e. body system code(s) plus any subsidiary Y codes including other approach codes in **Y45–Y52**, and **Y74–Y77**, **Y79** and **Y85** used to enhance the body system code, see also **PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)**). The exception to this is **PCSY11: Gestational age (Y95)**.

When a code from one of the following categories is used to supplement a body system code, the type of image control must be sequenced after the supplementary code:

- **L76.- Endovascular placement of stent**
- **L89.- Other endovascular placement of stent**
- **O20.- Endovascular placement of stent graft**
- **V55.- Levels of spine**

Where the type of image control has not been documented and the body system code description does not state image control, **Y53.9 Unspecified approach to organ under image control** or **Y78.9 Unspecified arteriotomy approach to organ under image control** must be assigned directly after the codes for the procedure.

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, unless instructional notes provide an exception.

Codes that state the type of image control in the code description, for example **L72.6 Intravascular ultrasound of artery NEC**, do not require a code from **Y53 Approach to organ under image control** or **Y68 Other approach to organ under image control**

unless the code provides additional detail about the type of image control, for example, **Y68.1 Approach to organ under contrast enhanced ultrasonic control.**

A code to classify the image control must not be assigned where image control has been used to:

- check the anatomical position of an organ/fracture site before, during or after a procedure
- check the position of a prosthesis/fixator after insertion
- confirm a procedure is complete

Codes within category **Y78 Arteriotomy approach to organ under image control** must only be assigned when 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
- cutting of artery

The arteriotomy will always require closure with either suture or clips to the overlying skin and a code to classify the method of closure must not be assigned in addition.

**See also: PCSY11: Gestational age (Y95)**

The majority of interventions that are undertaken on arteries by radiologists and some surgeons are referred to as Interventional Radiology procedures. 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:

*Balloon dilatation of oesophagus using fluoroscopic guidance*

- G21.4 Intubation of oesophagus NEC**
- Y40.3 Balloon dilation of organ NOC**
- Y53.4 Approach to organ under fluoroscopic control**

*Stereotactic laser ablation of thalamic lesion using frontal burr hole approach and navigation-guidance*

- A03.2 Stereotactic ablation of tissue of thalamus**
- Y46.2 Frontal open approach to contents of cranium**
- Y08.4 Laser destruction of lesion of organ NOC**
- Y68.5 Approach to organ under navigation guided 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**

### **PCSY16: Minimally invasive approach (Y77.3)**

**Y77.3 Minimally invasive approach to organ** must only be used for procedures performed through minimal incisions that do not utilise a microscopic or robotic approach (**Y45**), or an endoscopic or percutaneous endoscopic approach (**Y85** or **Y74-Y76**).

Any uncertainty as to whether a procedure has been performed using a minimally invasive incision must be clarified with the responsible consultant in order to ensure correct code assignment.

**See:**

- **PChSC1: Minimally invasive glaucoma surgery (MIGS)**
- **PCSY6: Approach to organ (Y45–Y52, Y74-Y77, Y79 and Y85)**
- **PCSY7: Approach to organ under image control (Y53, Y68 and Y78)**

In OPCS-4, minimally invasive refers to a technique that utilises smaller incisions to insert specialised instruments and visualisation tools to minimise disruption to surrounding tissues. This term is often used in joint replacement and glaucoma surgery.

### **Examples:**

*Minimally invasive video-assisted partial thyroidectomy (responsible consultant confirms that a small incision was made above the sternal notch and an endoscope was inserted through the incision and partial excision of the thyroid lobe was carried out)*

**B08.6 Partial thyroidectomy NEC**  
**Y85.8 Other specified endoscopic approach to organ**

*Minimally invasive surgical fusion of the sacroiliac (SI) joint under fluoroscopic guidance (responsible consultant confirms that the SI joint was accessed laterally through a small incision made in the buttock to reach the ilium)*

**W62.1 Primary arthrodesis and internal fixation of joint NEC**

**Y77.3 Minimally invasive approach to organ**

*Note: Use a subsidiary code to identify method of image control (Y53)*

**Y53.4 Approach to organ under fluoroscopic control**

**Z84.1 Sacroiliac joint**

*Transanal Minimally Invasive Surgery (TAMIS) with excision of rectal adenoma (responsible consultant confirms an endoscope was inserted via a port placed in the anus. The rectal lesion was identified and excised using endoscopic instruments)*

**H41.2 Peranal excision of lesion of rectum**

**Y85.8 Other specified endoscopic approach to organ**

### Coding grafts, harvests and donations

See:

- **PGCS12: Coding grafts and harvests of sites other than skin and bone**
- **PCSS3: Coding skin grafts and harvests**
- **PCSX12: Donation of skin (X46.2)**
- **PCSW14: Implantation of stem cells into joint**
- **PCSY12: Donor status (Y99).**

### Attention to procedures

See **PGCS22: Attention to procedures.**

### Staged procedures (Y70.3, Y71.1 and Y71.7)

See **PGCS18: Staged procedures.**

### Temporary operations

See **PGCS19: Temporary operations.**

### Failed percutaneous endoscopic and percutaneous transluminal procedures converted to open (Y71.4, Y71.5, Y72.1 and Y72.2)

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

### Endoscopic and percutaneous endoscopic procedures that do not have a specific code (Y74-Y77)

See **PGCS1: Endoscopic and percutaneous endoscopic procedures 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 (X57, 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 (X57, 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**

## 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 and bone*
- *PCSX8: Bone marrow transplantation and peripheral stem cell transplantation.*

**Example:**

*Allotransplantation 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**

*Laparoscopic cryoablation of lesion of right kidney, patient previously had their left kidney removed 3 years ago.*

#### **M10.4 Percutaneous 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 Percutaneous 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](http://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:**

- ***PRule 8: Surgical eponyms***
- ***PGCS1: Endoscopic and percutaneous endoscopic procedures that do not have a specific code***
- ***PGCS12: Coding grafts and harvests of sites other than skin and bone***
- ***PCSM11: Removal of vaginal and transobturator tape (M53 and M57)***
- ***PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)***

- **PCSY13: Insertion and removal of mesh (Y26 and Y28).**

Procedures for Stress Urinary Incontinence (SUI)		
Sex	Procedure	Procedure code(s)
Female	Colposuspension <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• Bladder neck suspension</li> <li>• Burch colposuspension</li> <li>• Burch procedure</li> </ul>	Open
		<b>M52.3</b>
		Laparoscopic
		<b>M52.3</b> <b>Y75.-</b>
Both	Injection, Botox (intravesical)	<b>M43.4</b>
Female	Insertion, retropubic tape <i>May also be described as insertion of:</i> <ul style="list-style-type: none"> <li>• RP tape</li> <li>• Tension free vaginal tape</li> <li>• TVT</li> <li>• Retropubic tension free vaginal tape</li> <li>• Synthetic mid-urethral sling</li> </ul> <i>*Paused procedure – see introduction to this guidance</i>	<b>M53.3*</b> <b>Y28.1-Y28.3</b> (if the type of mesh tape used is known)
Female	Insertion: <ul style="list-style-type: none"> <li>• Single incision tape</li> <li>• Single incision mini-sling</li> <li>• Single incision short mesh sling</li> </ul> <i>*Paused procedure – see introduction to this guidance</i>	<b>M57.1*</b> <b>Y28.1-Y28.3</b> (if the type of mesh tape used is known)

Female	<p>Insertion, transobturator mesh tape  <i>May also be described as insertion of:</i></p> <ul style="list-style-type: none"> <li>• TOT</li> <li>• TVTO</li> <li>• Transobturator tension free vaginal tape</li> <li>• Transobturator synthetic mid-urethral sling</li> </ul> <p><i>*Paused procedure – see introduction to this guidance</i></p>	<p><b>M53.6*</b>  <b>Y28.1-Y28.3</b> (if the type of mesh tape used is known)</p>
Male	<p>Insertion, transobturator mesh tape  <i>May also be described as:</i></p> <ul style="list-style-type: none"> <li>• Transobturator sling</li> <li>• TOT</li> <li>• Transobturator synthetic mid-urethral sling</li> </ul>	<p><b>M64.7</b>  <b>Y28.1-Y28.4</b></p>
Female	<p>Sling, fascial - Aldridge sling  <i>May also be described as (with fascia harvested from the abdominal wall):</i></p> <ul style="list-style-type: none"> <li>• Traditional retropubic sling</li> <li>• Autologous fascial sling</li> <li>• Native tissue sling</li> <li>• Autologous Supra-pubic sling</li> </ul>	<p><b>M51.3</b>  <b>Y60.3</b></p>
Female	<p>Sling, fascial - Sling on a string  <i>May also be described as:</i></p> <ul style="list-style-type: none"> <li>• Traditional retropubic sling</li> <li>• Autologous fascial sling</li> <li>• Native tissue sling</li> <li>• Autologous Supra-pubic sling</li> </ul>	<p><b>M51.3</b>  <b>Y60.-</b></p>
Female	<p>Supra-pubic sling NEC</p>	<p><b>M52.1</b>  <b>Y50.3</b>  <b>Y60.-</b></p>

Procedures for Pelvic Organ Prolapse (POP)		
Male or Female	Procedure	Procedure code(s)
Female	Cervicopexy, sacrospinous	Q57.2 Y50.3
Female	Colpopexy, infracoccygeal <i>May also be described as Infracoccygeal vault mesh suspension</i>  <i>*Paused procedure – see introduction to this guidance</i>	P24.6* Y28.1-Y28.4
Female	Colpopexy, sacrospinous	P24.7
Female	Fixation, iliococcygeal	P24.7
Female	Fixation, sacrospinous, uterus using mesh  <i>*Paused procedure – see introduction to this guidance</i>	Q57.2* Y50.3 Y28.1-Y28.4
Female	Hysteropexy <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• Sacrohysteropexy</li> <li>• Sacrocervicopexy</li> <li>• Sacrocolpohysteropexy</li> </ul>	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
		<b>Q57.4</b>
		Laparoscopic approach
		<b>Q57.4</b> <b>Y75.-</b>
Female	McCall Culdoplasty	Open
		<b>P31.1</b>
		Laparoscopic approach
		<b>P31.1</b> <b>Y75.-</b>
Female	Repair, vagina anterior <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• Anterior colporrhaphy</li> <li>• Cystocele repair</li> </ul> <p><i>*Paused procedure – see introduction to this guidance</i></p>	<b>P23.2</b>
		With mesh reinforcement/ using mesh
		<b>P23.6*</b> <b>Y28.1-Y28.3</b> (if the type of mesh tape used is known)
		With Manchester repair/ amputation of cervix uteri
		<b>P22.2</b>
Female	Repair, vagina posterior <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• Posterior colporrhaphy</li> <li>• Rectocele repair</li> </ul> <p><i>*Paused procedure – see introduction to this guidance</i></p>	<b>P23.3</b>
		With mesh reinforcement/ using mesh
		<b>P23.7*</b> <b>Y28.1-Y28.3</b> (if the type of mesh tape used is known)
		With Manchester repair/ amputation of cervix uteri

		<b>P22.3</b>
Female	Repair, vagina anterior and posterior <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• <i>Anterior and posterior colporrhaphy</i></li> <li>• <i>Cystocele and rectocele repair</i></li> </ul>	<b>P23.1</b>
		With Manchester repair/ amputation of cervix uteri
		<b>P22.1</b>
Female	Repair, Manchester <i>May also be described as amputation of cervix uteri</i> <i>Excludes when performed with Anterior and/or posterior colporrhaphy – P22.1-P22.3</i>	<b>Q01.1</b>
Female	Repair, rectoenterocele	<b>P23.4</b>
Female	Sacrocolpocervicopexy	Open
		<b>P24.2</b> <b>Y28.1-Y28.4</b> (if mesh is used)
		Laparoscopic approach
		<b>P24.2</b> <b>Y75.-</b> <b>Y28.1-Y28.4</b> (if mesh is used)
Female	Sacrocolpohysteropexy	Open
		<b>Q54.5</b> <b>Y28.1-Y28.4</b> (if mesh is used)
		Laparoscopic approach
		<b>Q54.5</b> <b>Y75.-</b> <b>Y28.1-Y28.4</b> (if mesh is used)
Female	Slingplasty, posterior intravaginal	<b>Q54.6*</b>

	<i>*Paused procedure – see introduction to this guidance</i>	<b>Y28.1-Y28.4</b> (if mesh is used)
Female	Suspension, mesh, infracoccygeal, uterine  <i>*Paused procedure – see introduction to this guidance</i>	<b>Q54.6*</b> <b>Y28.1-Y28.4</b>
<b>Procedures for Rectal Prolapse (both male and female)</b>		
<b>Procedure</b>		<b>Procedure code(s)</b>
Rectopexy, abdominal posterior resection		Without mesh
		<b>H35.3</b> <b>H10.-</b> (if the sigmoid is resected)
		With mesh
		<b>H35.2</b> <b>Y28.1-Y28.4</b> <b>H10.-</b> (if the sigmoid is resected)
Rectopexy, ventral mesh <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• <i>Anterior rectopexy with mesh</i></li> <li>• <i>VMR</i></li> </ul>		Open
		<b>H35.5</b> <b>Y28.1-Y28.4</b>
		Laparoscopic
		<b>H35.5</b> <b>Y75.-</b> <b>Y28.1-Y28.4</b>
Altemeier procedure		<b>H33.7</b>
Delorme procedure		<b>H42.5</b> or <b>H33.7</b> or <b>H42.6</b> or <b>H42.8</b>

Removal of tapes inserted for SUI		
Male or Female	Procedure	Procedure code(s)
Female	Removal, endoscopic/cystoscopic transurethral, mesh erosion from urethra or bladder: <ul style="list-style-type: none"> <li>• Retropubic tape</li> <li>• RP tape</li> <li>• Tension free vaginal tape</li> <li>• TVT</li> <li>• Transobturator tape</li> <li>• TOT</li> </ul>	Urethra
		<b>M78.1</b> <b>Y26.6 or Y26.7</b>
		Bladder
		<b>M44.5</b> <b>Y26.6 or Y26.7</b>
Female	Removal, retropubic tape <i>May also be described as removal of:</i> <ul style="list-style-type: none"> <li>• <i>RP tape</i></li> <li>• <i>Tension free vaginal tape</i></li> <li>• <i>TVT</i></li> <li>• <i>Retropubic tension free vaginal tape</i></li> <li>• <i>Synthetic mid-urethral sling</i></li> </ul>	Total
		Combined vaginal and laparoscopic approach
		<b>M53.4</b> <b>Y50.3</b> <b>Y75.-</b>
		Combined vaginal and abdominal (open) approach
		<b>M53.4</b> <b>Y50.3</b> <b>Y50.2</b>
		Partial - <i>may involve removing vaginal, abdominal or subcuticular portions of the tape.</i>
		Laparoscopic approach
		<b>M53.5</b> <b>Y75.-</b>
		Vaginal approach
		<b>M53.5</b> <b>Y50.3</b>
Abdominal (open) approach		
<b>M53.5</b> <b>Y50.2</b>		

Female	Removal: <ul style="list-style-type: none"> <li>• Single incision tape</li> <li>• Single incision mini-sling</li> <li>• Single incision short mesh sling</li> </ul>	Total	Vaginal approach
			<b>M57.2</b> <b>Y50.3</b>
			Combined vaginal and groin incision/dissection approach
			<b>M57.2</b> <b>Y50.3</b> <b>Y77.2</b>
		Partial - <i>may include the removal of hooks or anchors.</i>	Vaginal approach
			<b>M57.3</b> <b>Y50.3</b>
			Groin incision/dissection approach
			<b>M57.3</b> <b>Y77.2</b>
Female	Removal, transobturator mesh tape <i>May also be described as removal of:</i> <ul style="list-style-type: none"> <li>• <i>TOT</i></li> <li>• <i>TVTO</i></li> <li>• <i>transobturator tension free vaginal tape</i></li> </ul>	Total	Combined vaginal and groin incision/dissection approach
			<b>M53.7</b> <b>Y50.3</b> <b>Y77.2</b>
			Combined abdominal (open), vaginal and groin incision/dissection approach
			<b>M53.7</b> <b>Y50.2</b> <b>Y50.3</b> <b>Y77.2</b>

			Combined laparoscopic, vaginal and groin incision/dissection approach
			<b>M53.7</b> <b>Y75.-</b> <b>Y50.3</b> <b>Y77.2</b>
		Partial - may involve removing vaginal, abdominal or subcuticular portions of the tape.	Vaginal approach
			<b>M57.4</b> <b>Y50.3</b>
			Groin incision/dissection approach
			<b>M57.4</b> <b>Y77.2</b>
Male	Removal, transobturator mesh tape <i>May also be described as:</i> <ul style="list-style-type: none"> <li>• <i>TOT (mesh)</i></li> <li>• <i>Transobturator synthetic sling (mesh)</i></li> </ul>	Total	Open approach
			<b>M60.5</b> <b>Y26.7</b>
			Laparoscopic approach
			<b>M60.5</b> <b>Y75.-</b> <b>Y26.7</b>
		Partial	<b>M60.6</b> <b>Y26.6</b>
<b>Removal of mesh inserted for POP</b>			
<b>Male or Female</b>	<b>Procedure</b>		<b>Procedure code(s)</b>
Female	Removal, mesh implanted during previous repair of uterine prolapse	Total	Laparoscopic approach
			<b>Q54.7</b> <b>Y75.-</b> <b>Y26.7</b>

			Vaginal approach
			<b>Q54.7</b> <b>Y50.3</b> <b>Y26.7</b>
		Partial	Laparoscopic approach
			<b>Q57.1</b> <b>Y75.-</b> <b>Y26.6</b>
			Vaginal approach
			<b>Q57.1</b> <b>Y50.3</b> <b>Y26.6</b>
Female	Removal, mesh inserted during previous repair of vaginal prolapse	Total	Vaginal and groin incision/dissection approach
			<b>P28.1</b> <b>Y50.3</b> <b>Y77.2</b> <b>Y26.7</b>
			Vaginal approach
			<b>P28.1</b> <b>Y50.3</b> <b>Y26.7</b>
		Partial	Vaginal and groin incision/dissection approach
			<b>P28.2</b> <b>Y50.3</b> <b>Y77.2</b> <b>Y26.6</b>

			Vaginal approach
			<b>P28.2</b> <b>Y50.3</b> <b>Y26.6</b>
Female	Removal, mesh implanted during previous repair of vaginal vault prolapse	Total	Laparoscopic approach
			<b>P30.1</b> <b>Y75.-</b> <b>Y26.7</b>
			Vaginal approach
			<b>P30.1</b> <b>Y50.3</b> <b>Y26.7</b>
		Partial	Laparoscopic approach
			<b>P30.2</b> <b>Y75.-</b> <b>Y26.6</b>
			Vaginal approach
			<b>P30.2</b> <b>Y50.3</b> <b>Y26.6</b>
<b>Other procedures for POP and SUI procedure complications</b>			
Female	Dissection, buttock <i>Code in addition when performed with removal of mesh</i>		<b>T83.4</b> <b>Z90.1</b>
Female	Division, suburethral tape NEC		<b>M57.7</b>
Female	Division, tension-free vaginal tape		<b>M57.5</b>
Female	Division, transobturator tape		<b>M57.6</b>

Female	Martius fat graft		Code describing the structure that is being repaired <b>Y67.2</b> <b>Z44.7</b>
Female	Oversewing, exposed or eroded vaginal mesh tape		<b>P29.6</b>
Female	Plication, mesh	Inserted during previous sacrocolpopexy	Open
			<b>P30.3</b>
			Laparoscopic approach
			<b>P30.3</b> <b>Y75.-</b>
		Inserted during previous sacrohysteropexy or sacrocervicopexy	Open
			<b>Q57.3</b>
			Laparoscopic approach
			<b>Q57.3</b> <b>Y75.-</b>
<b>Other procedures – Miscellaneous</b>			
Female	Excision, diverticulum of urethra		Open
			<b>M72.3</b>
			Vaginal approach
			<b>M72.3</b> <b>Y50.3</b>

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## SUMMARY OF CHANGES

This section provides notification of all changes to the National Clinical Coding Standards OPCS-4, for use from 1 April 2026.

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.

## RETIRED NATIONAL CLINICAL CODING STANDARDS OR GUIDANCE

The table below lists the National Clinical Coding Standards and guidance which have been retired as the instruction or guidance has moved to the OPCS-4.11 Alphabetical Index, notes within the OPCS-4.11 Tabular list and/or Supplementary information. The last column in the table shows where the instruction or guidance can now be found.

More information about specific retirements can be found within the specific summary of changes chapter.

Chapter	Retired National Clinical Coding Standard or Guidance	New location
A	<b>PCSA1: Guide tube anterior cingulotomy (A03.1)</b>	Alphabetical Index - Section V
A	<b>PCSA2: Pain relief procedures</b>	Alphabetical Index - Section I and Section V
B	<b>PCSB3: Evacuation of post-operative haematoma from breast</b>	Alphabetical Index - Section V
B	<b>Parathyroid washout (B16.4) guidance</b>	Tabular list note
E	<b>PCSE1: Laryngopharyngectomy (E19 and E29)</b>	Alphabetical Index - Section V
E	<b>PCSE2: Diagnostic fibreoptic endoscopic examination of lower respiratory tract (E49)</b>	Alphabetical Index - Section I and Section V
E	<b>PCSE3: Endobronchial ultrasound-guided transbronchial needle aspiration of mediastinum (E63.4)</b>	Alphabetical Index - Section V
E	<b>PCSE6: Nasendoscopy</b>	Alphabetical Index - Section V
G	<b>PCSG1: Non-endoscopic oesophageal balloon dilation under image control (G21.4)</b>	Alphabetical Index - Section V

<b>G</b>	<b>PCSG2: Non endoscopic removal of percutaneous endoscopic gastrostomy (G34.5 and Y03.7)</b>	Alphabetical Index - Section V
<b>G</b>	<b>G30.5 Maintenance of gastric band guidance</b>	Alphabetical Index - Section I
<b>G</b>	<b>PCSG4: Removal or renewal of gastric balloon (G48.6)</b>	Alphabetical Index - Section V
<b>G</b>	<b>PCSG6: Endoscopic insertion of nasogastric or nasojejunal feeding tube (G47.5 and G67.5)</b>	Alphabetical Index - Section V
<b>H</b>	<b>PCSH1: Closure or reversal of Hartmann's procedure (H15.4)</b>	Alphabetical Index - Section V
<b>H</b>	<b>PCSH4: Antegrade colonic enema (H62.5)</b>	Alphabetical Index - Section V
<b>J</b>	<b>PCSJ1: Selective internal radiotherapy (SIRT) of liver using microspheres (J12.3)</b>	Alphabetical Index - Section V
<b>J</b>	<b>PCSJ4: Transarterial chemoembolisation (TACE) of the liver</b>	Alphabetical Index - Section V
<b>K</b>	<b>PCSK1: Transcatheter aortic valve implantation (K26)</b>	Alphabetical Index - Section V
<b>K</b>	<b>PCSK5: Insertion of ventricular assist device (K54 and K56.2)</b>	Alphabetical Index - Section I and Section III
<b>K</b>	<b>PCSK6: Ablation of the heart with 3D mapping (K58.6)</b>	Tabular list note and supplementary information
<b>K</b>	<b>PCSK7: Implantation and renewal of cardiac resynchronisation therapy defibrillator (K59.6 and K59.7)</b>	Tabular list note and Alphabetical Index – Section I
<b>K</b>	<b>PCSK9: Coronary lithotripsy (K50.8 and K75.-)</b>	Tabular list note
<b>L</b>	<b>PCSL3: Embolisation of uterine fibroids (L71.3)</b>	Alphabetical Index - Section V
<b>L</b>	<b>PCSL7: Aneurysm sizes (O01)</b>	Tabular list notes
<b>M</b>	<b>PCSM1: Percutaneous drainage of kidney (M13.2)</b>	Tabular list note
<b>M</b>	<b>PCSM10: Non-endoscopic microwave prostatectomy (M70.8)</b>	Alphabetical Index - Section V
<b>M</b>	<b>PCSM12: Cystoscopy with cystodiathermy</b>	Alphabetical Index - Section I
<b>M</b>	<b>PCSM8: Transurethral incision of male bladder neck and prostate (M66.2)</b>	Tabular list note and Alphabetical Index – Section I, Section II and Section V
<b>M</b>	<b>PCSM9: Radioactive seed implantation into prostate (M70.6)</b>	Alphabetical Index - Section V
<b>M</b>	<b>Radioactive seed implantation into prostate (M70.6) and Implantation of radioactive substance into prostate (M71.2) guidance</b>	Supplementary information
<b>N</b>	<b>PCSN1: Injection of papaverine for impotence (N32.4)</b>	Alphabetical Index - Section I
<b>P</b>	<b>PCSP1: Refashioning of episiotomy scar (P13.8 and S60.4)</b>	Alphabetical Index - Section V

Q	<b>PCSQ2: Dilation, curettage (D&amp;C), hysteroscopy and intrauterine coil (Q10.3, Q10.8, Q18.8, Q18.9, Q12)</b>	Tabular list notes and Alphabetical Index - Section I and Section III
Q	<b>PCSQ3: In vitro fertilisation (Q13.1, Q21.1 and Q38.3)</b>	Tabular list notes
Q	<b>PCSQ4: Magnetic Resonance Image-guided Focused Ultrasound to lesion of the uterus (Q20.6)</b>	Alphabetical Index - Section V
P	<b>PCSQ1: Colposcopy with punch biopsy (Q03.4 and Q55.4)</b>	Tabular list notes
R	<b>PCSR1: Artificial rupture of membranes (R14.1)</b>	Alphabetical Index - Section I and Section III
S	<b>Continuous blood glucose monitoring devices guidance</b>	Alphabetical Index – Section I
T	<b>PCST1: Release of tennis elbow (T69 or W78)</b>	Alphabetical Index - Section V
T	<b>PCST2: Release of trigger finger (T72.3)</b>	Alphabetical Index - Section V
T	<b>Scanning of sentinel lymph node (T91.2) guidance</b>	Tabular list note
V	<b>PCSV2: LeFort osteotomies (V10.2, V10.3 and V10.4)</b>	Alphabetical Index - Section II
V	<b>Fixation of mandible guidance</b>	Alphabetical Index - Section I
V	<b>PCSV4: Primary percutaneous endoscopic excision of thoracic intervertebral disc</b>	Tabular list notes and Alphabetical Index - Section V
V	<b>V40 Stabilisation of spine guidance</b>	Tabular list notes
V	<b>PCSV6: Magnetic adjustment of spinal growing system (V41.6)</b>	Alphabetical Index - Section V
V	<b>PCSV5: Lumbar interbody fusion (V33.3, V33.6, V38.5, V38.6 and V51.1)</b>	Alphabetical Index – Section I and Section III
W	<b>PCSW11: Hybrid knee replacement (O18.1)</b>	Alphabetical Index - Section V
W	<b>PCSW2: Tension band wiring of patella (W21.4)</b>	Alphabetical Index - Section V
W	<b>PCSW6: Unicompartmental knee replacement (W58.1)</b>	Tabular list note and Alphabetical Index – Section V
W	<b>PCSW7: Ozaki procedure (W76.1)</b>	Alphabetical Index - Section II
W	<b>PCSW9: Aspiration of prosthetic joint (W90.1)</b>	Tabular list notes and Alphabetical Index – Section I
W	<b>W08.7 Excision of accessory ossicle guidance box</b>	Tabular list note
X	<b>PCSX11: Donation of organ (X45)</b>	Tabular list note
X	<b>PCSX15: Evaluation of cardioverter defibrillator (X50.5)</b>	Tabular list note
X	<b>PCSX7: Red Cell Survival procedure (X35.8)</b>	Alphabetical Index – Section I

The table below lists the National Clinical Coding Standards and guidance which have been retired due to other reasons which are listed in the last column in the table.

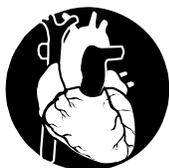
More information about specific retirements can be found within the specific summary of changes chapter.

Chapter	Retired National Clinical Coding Standard or Guidance	Reason for retirement
General	<b>PGCS17: Maintenance and attention to procedures</b>	Replaced with <b>PGCS22: Attention to procedures</b>
A	<b>PCSA6: Evoked potential recording (A84.4)</b>	New codes
A	<b>PCSA3: Neurostimulators (A09, A33, A48 and A70)</b>	Replaced with <b>PCSA9: Spinal and peripheral nerve neurostimulators (A46, A48, A70, A72)</b> and <b>PCSA10: Cranial nerve neurostimulators (A33)</b>
K	<b>PCSK3: Coronary arteriography with fractional flow reserve measurement or pressure wire studies and coronary angioplasty using fractional flow reserve</b>	Replaced with <b>PCSK11: Coronary angioplasty using fractional flow reserve</b> and new code
L	<b>PCSL2: Haemorrhoidal artery ligation (L70.3)</b>	New code
L	<b>PCSL4: Fistuloplasty of arteriovenous fistula (L74.3)</b>	New code
R	<b>PCSR2: Intravenous augmentation when in labour (R15)</b>	New codes
V	<b>PCSV1: Temporal bone excision (V05.8)</b>	New code
V	<b>PCSV5: Lumbar interbody fusion (V33.3, V33.6, V38.5, V38.6 and V51.1)</b>	Replaced with <b>PCSV8: Instrumented lumbar fusion (V40.4)</b>
Y	<b>PCSY5: Endoscopic ultrasound staging examination of organ NOC (Y41.2)</b>	Replaced with <b>PGCS23: Coding endoscopic ultrasound (EUS) procedures</b>
Y	<b>Y79 Approach to organ through artery guidance</b>	Replaced with updates to <b>PCSY6: Approach to organ (Y45–Y52, and Y74–Y77, Y79 and Y85)</b> and <b>PCSY7: Approach to organ under image control (Y53, Y68 and Y78)</b>
X	<b>PCSX6: Intravenous induction of labour (X35.1)</b>	Code retired

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## Changes between National Clinical Coding Standards OPCS-4 version 13.0 (April 2026) to 13.1 (April 2026).

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### CHAPTER K HEART (K01–K79)

#### 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 4<sup>th</sup> 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 **Y77.4 Transluminal approach to organ through 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 **Y77.4** must be assigned after each open procedure code.

##### **See also:**

- **PCSY6: Approach to organ (Y45–Y52, Y74-Y77, Y79 and Y85)**
- **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**

**Y77.4 Transluminal approach to organ through vein**

~~**Y76.8 Other specified percutaneous endoscopic approach 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**

**Y77.4 Transluminal approach to organ through vein**

~~**Y76.8 Other specified percutaneous endoscopic approach 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**



## CHAPTER U DIAGNOSTIC IMAGING, TESTING AND REHABILITATION (U01–U54)

### Coding standards and guidance

#### PCSU1: Diagnostic imaging procedures (U01–U18, U20–U21, U35–U37 and U42)

##### 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 NEC**, **C87.1 Digital imaging of retina NEC** and scanning codes within the range **R36–R43**, the body system chapter code **must** be used in preference to the diagnostic imaging codes within Chapter U.

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 ~~**U0118**~~ **U01–U18** and **U20–U21** and their extended categories **U35–U37** and **U42** must only be used in an outpatient setting, or when the patient has been admitted solely for the purpose of a diagnostic imaging procedure/intervention. The exceptions to this are:

- **Magnetic Resonance Imaging (MRI)**
- **Computed Tomography (CT)**
- **U17.7 Wireless capsule endoscopy of digestive tract**

- **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 diagnostic imaging codes in Chapter U 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)**.

The diagnostic imaging codes in Chapter U that classify nuclear medicine imaging procedures do not require the addition of codes from categories **Y97** or **Y98** unless there is a note at code level instructing otherwise – 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 are **PCSU8: Cardiac computed tomography for calcium scoring and cardiac computed tomography angiography (U10.2)**, **PCSU9: Bone densitometry (U13.1)** and **PCSU11: Vascular ultrasound scans**.

### **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.

## Changes between National Clinical Coding Standards OPCS-4 version 12.0 (April 2025) to 13.0 (April 2026).

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### 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 [4](#): 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 [and common procedures and combinations](#).

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 Classification of Interventions and Procedures \(OPCS-4\)](#) 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 coordinated 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 2006, the classification has been regularly updated. The following table lists OPCS-4 versions and the financial year in which they were mandated for use:](#)

<a href="#">Financial Year</a>	<a href="#">Version of OPCS-4</a>
<a href="#">Up to 31 March 2006</a>	<a href="#">OPCS-4.2</a>
<a href="#">1 April 2006 – 31 March 2007</a>	<a href="#">OPCS-4.3</a>
<a href="#">1 April 2007 – 31 March 2009</a>	<a href="#">OPCS-4.4</a>
<a href="#">1 April 2009 – 31 March 2011</a>	<a href="#">OPCS-4.5</a>
<a href="#">1 April 2011 – 31 March 2014</a>	<a href="#">OPCS-4.6</a>
<a href="#">1 April 2014 – 31 March 2017</a>	<a href="#">OPCS-4.7</a>
<a href="#">1 April 2017 – 31 March 2020</a>	<a href="#">OPCS-4.8</a>
<a href="#">1 April 2020 – 31 March 2023</a>	<a href="#">OPCS-4.9</a>
<a href="#">1 April 2023 – 31 March 2026</a>	<a href="#">OPCS-4.10</a>
<a href="#">1 April 2026 – until further notice</a>	<a href="#">OPCS-4.11</a>

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.

[The overall governance for OPCS-4 is provided by the UK Digital Vocabularies \(DigiVox\) Strategy Board, which is comprised of the national informatics leads for all four UK member countries.](#)

[The UK Classifications Technical Advisory Committee, which is a sub-committee of the UK DigiVox Strategy Board, provides oversight of OPCS-4 content updates and compliance with editorial principles. The Committee is a panel of classification experts from the UK member countries.](#)

## The ~~four-step~~ coding process

[The coding process is the basis of clinical coding and is designed to ensure accurate and consistent OPCS-4 code assignment. It is based on the Four-step coding process which was designed for use with the paper-based version of OPCS-4.](#)

[The process utilises the functionality available in the NHS Classifications Browser which is the primary source for access to OPCS-4.](#)

[The process can be carried out using two methods:](#)

- [\*\*The Classic method\*\* replicates the Four-step coding process with slight alterations to suit its use in the NHS Classifications Browser.](#)
- [\*\*The Search method\*\* utilises the search facility, meaning that steps 2 and 3 must be done together](#)

[Steps 1 and 4 are the same in both methods.](#)

[Coders may favour one method over the other and may use a combination of the two methods. It is important to find a method that suits the user, that ensures accuracy, consistency and efficiency, and that importantly uses both the OPCS-4 Volume II - Alphabetical Index and Volume I - Tabular List.](#)

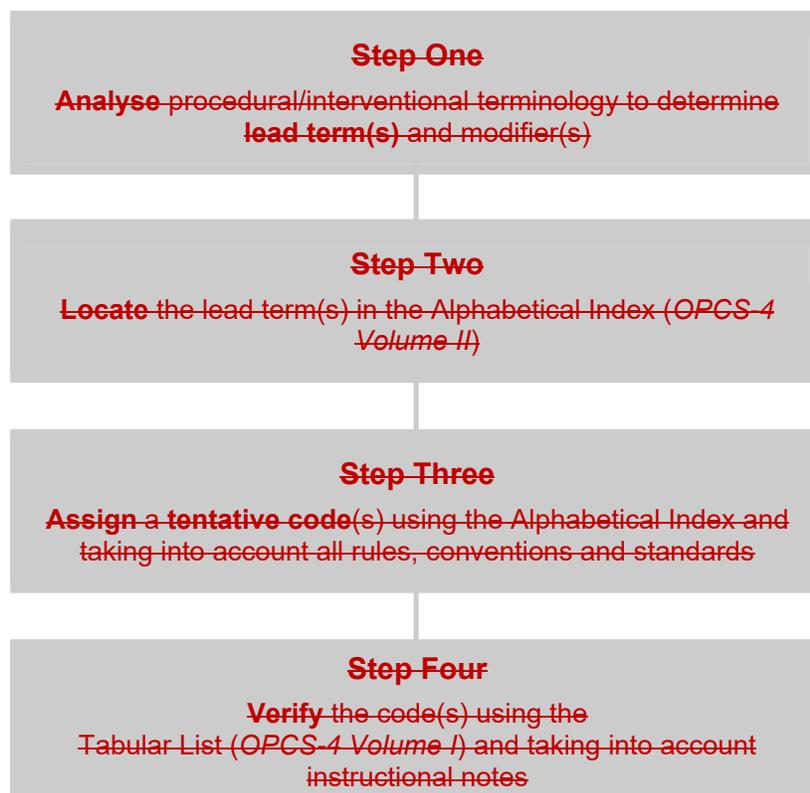
[These methods are summarised as follows:](#)

Step	Classic method	Search method
1	<b>Analyse</b> procedural/ interventional terminology to determine lead term(s) and modifier(s)	
2	<b>Locate</b> the lead term(s) in OPCS-4 Volume II - Alphabetical Index	<b>Search</b> for the lead term(s) and <b>assign a tentative code(s)</b> using OPCS-4 Volume II - Alphabetical Index
3	<b>Assign a tentative code(s)</b> using OPCS-4 Volume II - Alphabetical Index	
4	<b>Verify</b> the code(s) to ensure appropriate code selection using OPCS-4 Volume I - Tabular List	

[The full detail of each step is fully explored in training using national core curriculum training materials, and within the suite of documents that can be accessed on Delen.](#)

~~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.~~



~~Information on how to follow the coding process using the NHS Classifications Browser can be found on the Transition to electronic classifications page on Delen. The updated process is based on the four-step coding process and has been modified to utilise the functionality available in the NHS Classifications Browser.~~

## HOW TO USE THIS PUBLICATION

### 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.~~

#### 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.

Example within the *References* section of the *How to use this publication* guidance changed as the reference to **B16.4** has been retired.

## RULES OF OPCS-4

### 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~~ where absolutely necessary. If a ~~n-extraordinary~~ circumstance arises where a code's description is considered ~~invalid~~ obsolete, outdated or inaccurate (usually due to

changes in clinical practice and knowledge) a following full classification review) of the issue is undertaken. The ~~, the code, the associated~~ problem, an options appraisal, ~~to address it~~ and recommendation(s) are provided to the OPCS-4 Editorial ~~Board~~ Committee for a decision. The support of the relevant professional body ~~or would~~ clinician may also be required in these circumstances to provide appropriate clinical input.

In practice, the code is retired ~~in~~ from 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 (ToCE) (used to analyse the equivalent codes in the current and previous releases of OPCS-4).

Where a three-character category is retired all the four-character codes within it are also retired. Retired codes and categories are represented as follows:

**R03.-**      **Category retired – refer to introduction**  
**X15.3**      **Code retired – refer to introduction**

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

**OPCS-4.11:**

<a href="#">E63.2</a>	<a href="#">E63.3</a>	<a href="#">E63.4</a>	<a href="#">G80.3</a>	<a href="#">H05.2</a>	<a href="#">H06.1</a>
<a href="#">H06.3</a>	<a href="#">H06.5</a>	<a href="#">H07.5</a>	<a href="#">H08.2</a>	<a href="#">H08.3</a>	<a href="#">H08.6</a>
<a href="#">H09.6</a>	<a href="#">H10.1</a>	<a href="#">H10.6</a>	<a href="#">H11.6</a>	<a href="#">H30.3</a>	<a href="#">H30.4</a>
<a href="#">H30.5</a>	<a href="#">H44.3</a>	<a href="#">H68.-</a>	<a href="#">H69.-</a>	<a href="#">H70.-</a>	<a href="#">J17.-</a>
<a href="#">J53.-</a>	<a href="#">J74.-</a>	<a href="#">L74.1</a>	<a href="#">M10.5</a>	<a href="#">M11.2</a>	<a href="#">M11.3</a>
<a href="#">M21.1</a>	<a href="#">M27.-</a>	<a href="#">M30.4</a>	<a href="#">Q35.4</a>	<a href="#">Q36.2</a>	<a href="#">R40.2</a>
<a href="#">T46.1</a>	<a href="#">X35.1</a>	<a href="#">Y76.1</a>	<a href="#">Y76.2</a>	<a href="#">Y76.3</a>	<a href="#">Y76.4</a>
<a href="#">Y76.6</a>					

The OPCS-4.11 release saw an increase in the retirement of codes that are outdated or obsolete, including those due to changes to the classification of endoscopic and percutaneous endoscopic procedures.

**OPCS-4.10:**

<a href="#">P15.3</a>	<a href="#">G80.2</a>
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**OPCS-4.9**

<a href="#">L99.1</a>	<a href="#">M16.4</a>	<a href="#">M28.1</a>	<a href="#">M28.2</a>	<a href="#">M28.3</a>
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### OPCS-4.8:

<a href="#">M06.4</a>
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### OPCS-4.7:

<a href="#">R03</a>	<a href="#">X15.3</a>
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### OPCS-4.5:

<a href="#">X63.-</a>	<a href="#">X64.-</a>
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- ~~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

[The retired categories and codes, their full descriptions and the rationale for their retirement are listed within the OPCS-4.11 ToCE Specification, available in the OPCS-4.11 data files on TRUD.](#)

[See also PRule 12: Codes at risk of being used in error](#)

**PRule 6** updated to include the categories and codes retired in OPCS-4.11.

### **PRule 8: Surgical eponyms**

Section II Alphabetical Index of Surgical Eponyms within Volume II - Alphabetical Index ~~must not be used to assign codes~~ [must only be used as a guide when assigning OPCS-4 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~~is used to indicate the codes that ~~should~~may 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~~This section was not revised between 2008 and 2025, however in OPCS-4.11, implemented in April 2026, additions have been made to reflect the ongoing use of eponyms by clinicians and the need to assist coders in assigning accurate OPCS-4 codes.

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 with caution when assigning clinical codes and the coder refers to the procedural information so that code assignment fully reflects the procedure performed.

**PRule 8** has been amended to allow the use of Section II Alphabetical Index of Surgical Eponyms within Volume II - Alphabetical Index following the addition of some Eponyms in OPCS-4.11

#### **PRule 12: Codes at risk of being used in error**

The codes contained within the database '*OPCS-4 codes at risk of being assigned in error*', hosted on Delen, must be used with caution. Before assigning a code from the list, coders must ensure that the code correctly classifies the procedure documented within the medical record.

During the development of OPCS-4.11, clinical input suggested that certain codes may be obsolete or erroneous. Analysis of Hospital Episode Statistics (HES) and consultation with coding departments (via the Clinical Coding Managers Workspace) confirmed that some

codes were obsolete, inaccurate, or outdated. These were subsequently retired or altered in OPCS-4.11.

However, it was not possible to definitively confirm that all codes were obsolete, as some are still in use. To gather further evidence, a database of codes that are at risk of being used in error has been created to support their potential removal or modification in a future release.

The codes are categorised as follows:

- **Original purpose unclear**  
The code has been present in OPCS-4 for a number of years, but the purpose of the code is not clear
- **Potentially clinically inaccurate**  
Clinical feedback has indicated the code is clinically inaccurate but is still in use suggesting that source documentation reflects the code description
- **Potentially obsolete**  
Clinical feedback has indicated that the procedure classified is no longer performed
- **Potentially outdated**  
The code has been present in OPCS-4 for a number of years, but the procedure being described in the code description does not use contemporary language.

Each code also includes a reason for their potentially erroneous use.

The codes may be assigned if source documentation supports their use, but coding departments will be expected to submit anonymised documentation to [support.digitalservices@nhs.net](mailto:support.digitalservices@nhs.net) or our Customer Service Portal to help understand why and how they are being used.

The Terminology & Classifications Delivery Service will perform periodic data quality checks on the use of these codes. In cases where source documentation is missing, trusts will be contacted to determine the appropriateness of the code's use. Therefore, to proactively support this initiative, we encourage coding departments to conduct regular local data quality checks on their use of these codes.

**See also PRule 6: Retired categories and codes**

## **PRule 13: Section V Alphabetical Index of Common Procedures and Combinations**

When using Section V Alphabetical Index of Common Procedures and Combinations within Volume II – Alphabetical Index, coders must ensure the codes assigned fully reflect the procedure performed.

OPCS-4 codes must be assigned adhering to all relevant National Clinical Coding Standards even where these deviate from the listed codes. Examples where the additional codes may not appear within the Section V entry are:

- Laterality which must be assigned following **PCSZ2: Laterality of operation (Z94)**
- Approach codes, including image control. See **PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)** and **PCSY7: Approach to organ under image control (Y53, Y68 and Y78)**.

Care must also be taken where an eponym or surgical abbreviation is provided within Section V, see **PRule 8: Surgical eponyms** and **PRule 9: Surgical abbreviations**.

As additional codes may be added or removed to fully reflect a procedure, the sequencing provided within an entry is not intended to be prescriptive. Care must be taken to ensure that sequencing follows National Clinical Coding Standards and OPCS-4 Conventions.

Section V is provided to ensure consistent data is collected where a common procedure is documented in a way that is not easy to index, or a combination of codes are required to fully represent a common procedure.

The index entries do not follow the ‘what-where-how’ structure of Section I Alphabetical Index of Interventions and Surgical Procedures to enable more natural language to be used which can be searched in the NHS Classifications Browser.

### **Conventions used with Section V index entries**

Where any code from a category applies this appears as ‘.-’ at the end of the category, for example ‘**Y51.-**’. In principal/extended categories only the principal category will be listed but this means any code from either the principal or extended category is applicable.

Where a code is optional depending on how the procedure is documented these codes will appear in brackets within the entry, for example (**Y11.-**)

Abbreviations and alternative descriptions are included in brackets within the entry description, for example ‘Balloon dilation of ethmoid sinus (Balloon sinuplasty)’.

### **Feedback**

[As this is a new section, we would like to gather feedback on its use throughout the year and make improvements where necessary. Please provide any feedback and suggestions for improvement via this Microsoft Form.](#)

[To request additional entries please submit a request for change via the OPCS-4 Request Submission Portal as a minor change.](#)

## 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. [There will not be any entries under the lead term listed before the 'see' cross reference. For example:](#)

[Dilatation - see Dilation](#)

[Syringing - see Irrigation](#)

#### 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. [For example:](#)

[Destruction - see also Photodestruction](#)

[Excision Lesion - see also Excision site](#)

[See also PConvention 4: Alphabetical index entries](#)

### 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.

[The exception to this convention is \*PChSW4: Coding bone grafts\*](#)

#### **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

### **[PConvention 4: Alphabetical Index entries](#)**

[Section I Alphabetical Index of Interventions and Surgical Procedures is divided alphabetically by lead terms followed by modifiers.](#)

[Lead terms are generally the type of intervention/procedure performed or the interventional action, such as 'Ablation'.](#)

[Modifiers describe where the intervention/procedure has been done, i.e. the site, including any sub sites, and how the intervention/procedure has been done, such as 'laparoscopic', 'percutaneous', 'microwave' and 'stereotactic'.](#)

[Terms such as 'lesion' constitute a sub site. A lesion refers to any lump or bump, etc., that should not be present, e.g. cyst, tumour, ganglion abscess. An organ represents the site of the operation and refers to any anatomical part, either internal or external, e.g. stomach, brain, joint, skin.](#)

Lead terms and modifiers are capitalised and preceded by the appropriate category or code. Together, the category/code, lead term and modifiers form index entries.

Index entries are generally formed using the following standard format:

<u>OPCS-4 Code</u>	<u>Lead Term - Action</u>	<u>Modifier – Site/ subsite</u>	<u>Modifier – Action qualifier(s)</u>
	<u>The action that took place, or the intervention/procedure that was performed</u>	<u>The site/subsite where the action took place, or where the procedure was performed</u>	<u>How the action took place or how the intervention/procedure was done</u>

The lead term and modifiers are listed on one line, rather than listed at separate subdivisions. This means that lead terms and modifiers may be listed multiple times.

The Index also includes the following curtailed terms:

anast. = anastomosis  
endo. = endoscopic  
exam. = examination  
fibreop. = fiberoptic  
prox. = proximal  
recur. = recurrent  
U.G.I. = upper gastrointestinal

See also:

- *PRule 8 Surgical eponyms*
- *PRule 9: Surgical abbreviations*
- *PConvention 1: Cross references*
- *PConvention 3: Abbreviations*

Examples:

Q39.- Examination Fallopian Tube Endoscopic Percutaneous

Here the lead term (action) is ‘Examination’ the site/subsite modifier is Fallopian Tube’ and the action qualifiers are ‘Endoscopic Percutaneous’

K57.4 Ablation Accessory Pathway Transluminal Percutaneous

K62.2 Ablation Atrial Wall Atrial Flutter Transluminal Percutaneous

K57.5 Ablation Atrial Wall Transluminal Percutaneous NEC

The lead term of ‘Ablation’ is listed multiple times as there are multiple codes that classify ablation procedures.

[G45.- Biopsy Duodenum Prox. & Examination G.I. Tract Upper Endo. Fibreoptic](#)

[This Index entry includes the curtailed terms Prox. for proximal, G.I for Gastrointestinal, and Endo. for endoscopic.](#)

## GENERAL CODING STANDARDS AND GUIDANCE

### PGCS1: Endoscopic and [percutaneous endoscopic procedures](#) ~~minimal access operations~~ that do not have a specific code

When an endoscopic or [percutaneous endoscopic](#) ~~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 ~~are~~ required:

- Open procedure code
- ~~Y74–Y76Y77 minimal access~~ [percutaneous endoscopic](#) approach code [or Y85 endoscopic approach](#)
  - 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)

[See also PCSY6: Approach to organ \(Y45–Y52, and Y74-Y77, Y79 and Y85\)](#)

[The Tabular List contains categories that distinguish between endoscopic and percutaneous endoscopic procedures to ensure that procedures that can be performed via either route can be easily identified in the classification to allow for accurate data collection and analysis and appropriate reimbursement.](#)

[Endoscopic approach refers to a technique using a scope inserted via a natural orifice \(nostrils, mouth, anus, urethra, vagina\) or an artificial orifice \(stoma sites\), without requiring a separate skin incision. Examples include bronchoscopy, colonoscopy, cystoscopy, gastroscopy, hysteroscopy, and urethroscopy.](#)

[Percutaneous endoscopic approach refers to a technique using a scope inserted through skin incisions for visualisation and intervention within a body cavity or organ. Examples include arthroscopy, laparoscopy and mediastinoscopy.](#)

[This naming convention is consistent across all body system chapters even when only one approach is possible.](#) ~~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 fiberoptic 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**

[Y85.3 Endonasal endoscopic approach to organ](#)

~~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**~~

~~Thoracoscopic robotic-assisted coronary artery bypass graft (CABG) of one coronary artery~~

~~**K43.1 Prosthetic replacement of one coronary artery**  
**Y74.3 Robotic assisted thoracoscopic approach to thoracic cavity**~~

## 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 [as indicated by notes in the OPCS-4 tabular list, or at specific coding standards](#), 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.

**PGCS2** has been updated to remove the list of exceptions, as this is duplication of information present in other standards, or the OPCS-4 Tabular List. **H09.1** code description updated in OPCS-4.11.

## **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~~ are:

- [PCSH6 Colonoscopy and flexible sigmoidoscopy \(H20-H25, H38 and H39\)](#)
- **PCSJ2: Failed or abandoned endoscopic retrograde cholangiopancreatography (J43.9).**

**PGCS3** has been updated to add **PChSH1: Colonoscopy and flexible sigmoidoscopy (H20-H25, H38 and H39)** to the list of exceptions.

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

When a [percutaneous endoscopic](#) ~~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
- [An appropriate failed approach code from:](#)
  - [Y71.4 Failed percutaneous endoscopic approach converted to open NEC, or](#)
  - [Y71.5 Failed percutaneous transluminal approach converted to open, or](#)
  - [Y72.1 Failed robotic assisted percutaneous endoscopic approach converted to open, or](#)
  - [Y72.2 Failed video-assisted percutaneous endoscopic approach converted to open](#)
- ~~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 percutaneous endoscopic approach converted to open NEC](#) ~~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**

### 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.

[See also PCSY6: Approach to organ \(Y45–Y52, and Y74–Y77, Y79 and Y85\)](#)

#### Examples:

*Laparotomy with excision of cyst of left ovary*

**Q43.2 Excision of lesion of ovary**

**Z94.3 Left sided operation**

[Right primary total hip replacement \(THR\) using cement, performed through a 25cm skin incision](#)

[W37.1 Primary total prosthetic replacement of hip joint using cement](#)

[Z94.2 Right sided operation](#)

### 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 biopsies have been taken from different sites \(with a different site code\), assign a site code for each site](#)~~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(s) (for the site(s) 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 [a](#) 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 [or more](#) of these procedures is an excision, the biopsy/[biopsies](#) must only be coded if performed on a different site(s) to the excision(s).

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 fiberoptic (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 fiberoptic category.

### Examples:

*Fiberoptic endoscopic examination of upper gastrointestinal tract with biopsies of oesophagus and stomach*

#### **G45.1 Fiberoptic 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**

#### **Z27.1 Oesophagus**

#### **Z27.2 Stomach**

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

#### **H20.1 Fiberoptic endoscopic snare resection of lesion of colon during colonoscopy~~Fiberoptic 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 during flexible sigmoidoscopy~~Endoscopic snare resection of lesion of lower bowel using fiberoptic sigmoidoscope~~**

Includes: Descending colon  
Sigmoid colon  
~~Colon~~  
Rectum

**Note: Use a subsidiary site code as necessary**

#### Z28.6 Sigmoid colon

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

#### H20.1 Fibreoptic endoscopic snare resection of lesion of colon during colonoscopy~~Fibreoptic endoscopic snare resection of lesion of colon~~

Includes: ~~Caecum~~  
~~Mucosa of colon~~  
~~Mucosa of caecum~~  
Large Intestine  
Rectum

**Note: Use a subsidiary site code as necessary**

#### Z28.2 Caecum

#### Z28.4 Transverse colon

#### Z28.6 Sigmoid colon

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

#### H20.5 Fibreoptic endoscopic submucosal resection of lesion of colon during colonoscopy~~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 during colonoscopy~~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 during colonoscopy~~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 during colonoscopy](#)~~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.

The instruction to assign the biopsy site code to the furthest site has been changed to reflect the new coding standard **PGCS23: Coding endoscopic ultrasound (EUS) procedures** and to bring the instructions in line for consistent coding.

Code descriptions in the examples have been updated to reflect the changes to endoscopic procedure codes in OPCS-4.11.

### **PGCS12: Coding grafts and harvests of sites other than skin and bone**

Grafts (other than skin grafts [and bone grafts classified in Chapter W](#)) 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**
- [PChSW4: Coding bone grafts](#)
- **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:**

~~*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**~~

~~*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~~

*Endoscopic ~~m~~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**

#### ~~PGCS47: 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~~

**PGCS17** has been retired as 'maintenance' within body system codes has been replaced by 'Attention to' in OPCS-4.11.

#### PGCS21: Incision and drainage procedures

Where an incision is made for the purpose of drainage this must be classified to a drainage code.

Where there is no drainage code available, a .8 Other specified code from a category that describes the organ or structure which is being drained must be assigned with a subsidiary code from Y22.- Drainage of organ NOC.

See also PRule4: Category and code structure.

Where incision and drainage (I&D) is performed the incision is implicit in the drainage.

### **Examples:**

#### Incision and drainage of mouth lesion

**F42.8 Other specified other operations on mouth**

**Y22.9 Unspecified drainage of organ NOC**

#### Drainage of left external ear haematoma

**D04.1 Drainage of haematoma of external ear**

**Z94.3 Left sided operation**

### **PGCS22: Attention to procedures**

Where a specific code does not exist classifying the type of attention performed during a procedure, an 'attention to' code (from Chapters A-X) must be assigned.

A supplementary code from Chapter Y must be assigned in addition where it provides additional information about the type of attention.

Where flushing of a prosthesis is performed concurrently with either the insertion or renewal of a prosthesis, the flushing must not be coded in addition.

Programming or re-programming of devices must not be coded when performed concurrently with the insertion, renewal or implantation of a device.

In the absence of a specific code for the type of attention, attention to a prosthesis includes:

- Maintenance including:
  - Refilling of prosthesis, for example pumps
  - Flushing of prosthesis, for example catheters
  - Programming and re-programming of previously implanted device(s)
- Adjustment
- Correction

- [Conversion](#)
- [Removal](#)
- [Renewal](#)
- [Revision](#)
- [Re-siting](#)

**Examples:**

*[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](#)

*[Replacement of brain neurostimulator battery](#)*

- [A09.2 Attention to brain neurostimulator generator](#)
- [Y03.2 Renewal of prosthesis in organ NOC](#)

*[Reprogramming of spinal cord neurostimulator](#)*

- [A48.5 Reprogramming of spinal cord neurostimulator](#)

*[Insertion and flushing of a central venous catheter](#)*

- [L91.2 Insertion of central venous catheter NEC](#)

*[Renewal of cerebroventricular shunt](#)*

- [A14.1 Renewal of cerebroventricular shunt](#)

**[PGCS23: Coding endoscopic ultrasound \(EUS\) procedures](#)**

**[Diagnostic Endoscopic Ultrasound \(EUS\)](#)**

[Site codes are not required when an EUS examination without biopsy has been performed. This is an exception to \*\*\[PGCS10: Coding endoscopic procedures\]\(#\)\*\*.](#)

[Where a biopsy has been taken and the specific site of the biopsy is not stated in the code description, for example \*\*\[J79.1 Endoscopic ultrasound examination of hepatopancreatobiliary system and biopsy of lesion of hepatopancreatobiliary\]\(#\)\*\*](#)

[system](#), a site code must be assigned to identify the site of the biopsy. Where biopsies have been taken from different sites, (with a different site code), assign a site code for each site.

[A code\(s\) from T86 Sampling of lymph nodes or T87 Excision or biopsy of lymph node](#), followed by [Y85.4 Endoscopic ultrasonic approach to organ](#), must be assigned in addition to the EUS code where lymph nodes are sampled or biopsied during an EUS.

[Y20.4 Fine needle aspiration NOC](#) must be assigned in addition to the EUS code and/or the lymph node sampling/biopsy code when a fine needle aspiration (FNA) is performed.

[Y41.2 Endoscopic ultrasound staging examination of organ NOC](#) must be assigned in addition when an EUS is performed as a staging examination.

[Y41.3 Endoscopic ultrasound examination of organ NOC](#) must only be used, in addition to a body system code, in circumstances where a specific EUS code does not exist.

#### [Diagnostic EUS of hepatopancreatobiliary system \(J79\) with upper gastrointestinal endoscopy](#)

[Where an upper gastrointestinal endoscopy is performed prior to an EUS of the hepatopancreatobiliary system, or a biopsy is taken of the gastrointestinal tract with the EUS scope, a code from G45 Diagnostic fiberoptic endoscopic examination of upper gastrointestinal tract](#) must also be assigned in addition to a code from category [J79 Diagnostic endoscopic ultrasound examination of hepatopancreatobiliary system](#).

#### [Therapeutic EUS](#)

[Where a therapeutic procedure has been performed using EUS, Y85.4 Endoscopic ultrasonic approach to organ](#) must be assigned directly after the body system code for the procedure performed.

#### [See also:](#)

- [PGCS10: Coding endoscopic procedures](#)
- [PCSY6: Approach to organ \(Y45–Y52, Y74–Y77, Y79 and Y85\)](#)
- [PCSY7: Approach to organ under image control \(Y53, Y68 and Y78\)](#)

[FNA generally refers to the use of very thin needles to obtain samples of cells or fluid from a suspicious mass. In the context of EUS-guided aspiration, commonly used needle gauges include 19G, 22G, and 25G. While 19G is a larger "fine needle" often used for obtaining core biopsies \(fine needle biopsies \(FNB\)\) that yield more tissue for histology, both 22G and 25G needles are referred to as fine needles and are widely used for FNA procedures.](#)

**Examples:**

*Radial endobronchial ultrasound (EBUS) of the left lung*

**E58.9 Unspecified diagnostic endobronchial ultrasound examination of lung**  
**Z94.3 Left sided operation**

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

**E68.3 Endobronchial ultrasound examination of mediastinum**  
**T87.4 Excision or biopsy of mediastinal lymph node**  
**Y85.4 Endoscopic ultrasonic approach to organ**  
**Y20.4 Fine needle aspiration NOC**

*EUS of oesophagus: the report stated that EUS-FNA was undertaken for the staging of a newly diagnosed oesophageal adenocarcinoma*

**G16.4 Diagnostic fibreoptic endoscopic ultrasound examination of oesophagus and biopsy of lesion of oesophagus**  
**Y20.4 Fine needle aspiration NOC**  
**Y41.2 Endoscopic ultrasound staging examination of organ NOC**

*EUS of upper GI tract: the report stated that there were a large number of well demarcated lymph nodes in the mediastinum. A core biopsy was taken along with a fine needle aspirate of the mediastinal lymph nodes. The EUS did not pass beyond the oesophagus*

**G16.2 Diagnostic fibreoptic endoscopic ultrasound examination of oesophagus**  
**T87.4 Excision or biopsy of mediastinal lymph node**  
**Y85.4 Endoscopic ultrasonic approach to organ**  
**Y20.4 Fine needle aspiration NOC**

*EUS of hepatobiliary system: the report stated that a duodenal biopsy had been taken to rule out coeliac disease, further examination showed normal appearance of the pancreas and no common bile duct stones were noted*

**G45.1 Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract**  
**Z27.4 Duodenum**  
**J79.9 Unspecified diagnostic endoscopic ultrasound examination of hepatopancreatobiliary system**

*Note: It is not necessary to code additionally any mention of sites examined*

EUS of hepatobiliary system: the report stated that a fluid sample was obtained from a pancreatic cyst using a 25G needle (responsible consultant confirmed fine needle aspiration). The common bile duct appeared normal and there were no liver lesions

**J79.1 Endoscopic ultrasound examination of hepatopancreatobiliary system and biopsy of lesion of hepatopancreatobiliary system**

*Note: Use a subsidiary site code to identify the site of biopsy (Z30, Z31)*

**Y20.4 Fine needle aspiration NOC**

**Z31.1 Pancreas**

EUS-guided pancreatic necrosectomy

**J57.6 Pancreatic necrosectomy**

**Y85.4 Endoscopic ultrasonic approach to organ**



## CHAPTER A NERVOUS SYSTEM (A01–A84)

### Chapter standards and guidance

**O48.2 Awake brain surgery**, commonly referred to as ‘awake craniotomy’, is assigned in addition to codes from Chapter A Nervous system when surgery on the brain is conducted whilst the patient is awake.

### 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**~~

**PCSA1** has been retired due to the addition of a new combination index entry in Section V of the Alphabetical Index.

<b>PCSA2: Pain-relief-procedures</b>	
<b>Procedure</b>	<b>OPCS-4 code(s)</b>
Block, brachial plexus	<b>A73.5 + Z08.9</b>
Block, caudal long-acting pain relief  — destructive	<b>A52.2</b> <b>A54.1</b>
Block, cervical plexus long-acting pain relief  — destructive	<b>A73.5</b> <b>A60.5</b>
Block, coeliac plexus long-acting pain relief  — destructive, chemical  — destructive, cryotherapy  — destructive, radiofrequency  — destructive NEG	<b>A81.2</b> <b>A76.5</b> <b>A77.5</b> <b>A78.5</b> <b>A79.5</b>
Block, dorsal root ganglion nerve destructive NEG  — destructive, radiofrequency  — destructive, chemical	<b>A57.5 + Z07.-</b> <b>A57.3 + Z07.-</b> <b>A57.4 + Z07.-</b>
Block, facet joint	<b>V54.4 + V55.- + Z67.-</b>
Block, guanethidine long-acting pain relief  — destructive	<b>A81.2</b> <b>A76.-</b>

Block, intercostal nerve pain relief long acting	<b>A73.5 + O52.1</b>
Block, medial branch	<b>A73.5 + O42.-</b>
Block, peripheral nerve root pain relief	<b>A73.5 + site</b>
Block, pudendal acting pain relief long	<b>A73.5 + Z11.3</b>
Block/blockade, stellate ganglion long acting pain relief destructive, chemical destructive, cryotherapy destructive, radiofrequency destructive	<b>A81.1</b> <b>A76.8 + Z92.3</b> <b>A77.8 + Z92.3</b> <b>A78.8 + Z92.3</b> <b>A79.8 + Z92.3</b>
Block, sympathetic nerve relief long acting pain destructive, chemical destructive, cryotherapy destructive, radiofrequency destructive NEC	<b>A81.2</b> <b>A76.-</b> <b>A77.-</b> <b>A78.-</b> <b>A79.-</b>
Block, trigeminal nerve pain relief long acting destructive	<b>A36.5</b> <b>A26.3</b>
Cryoprobe peripheral nerve lesion	<b>A61.2 + site</b>
Denervation, trigeminal nerve pain relief destructive	<b>A36.5</b> <b>A26.3</b>
Denervation, medial branch nerve pain relief	<b>V48.- + V55.-</b>
Destruction spinal nerve, radiofrequency controlled, thermal	<b>A57.3</b>

<p><del>Epidural, for pain relief</del> <del>— dorsal,</del>  <del>cervical, thoracic</del></p> <hr/> <p><del>— lumbar</del></p> <hr/> <p><del>— sacral</del></p>	<p><del>A52.8 + Z06.-</del>  <del>A52.1</del>  <del>A52.2</del></p>
<p><del>Intrathecal pump</del> <del>—</del>  <del>implant</del></p> <hr/> <p><del>— refilling</del></p> <hr/> <p><del>— removal</del></p>	<p><del>A54.3</del>  <del>A54.4 + Y03.1</del>  <del>A54.5</del></p>
<p><del>Neurodestruction</del> <del>—</del>  <del>peripheral nerve</del></p> <hr/> <p><del>— sympathetic nerve</del></p>	<p><del>A60.5 + site</del>  <del>A76.-</del></p>
<p><del>Stimulator/neurostimulator dorsal column</del></p>	<p><del>A48.3 + Z06.2</del></p>

Pain relief procedures are classified in OPCS-4 according to whether they are destructive or non-destructive treatments. The term ‘nerve block’ may be used to describe both of these types of procedure. However, it is the method used, i.e. whether the nerve block is destructive or non-destructive that determines code assignment. 

Both destructive pain relief procedures which destroy or damage the nerve and non-destructive pain relief procedures which block or modulate nerve signals without causing permanent damage to the nerve are performed to achieve long term pain relief.

Where there is any uncertainty whether or not the procedure performed is destructive, clarification should be sought from the responsible consultant.

Examples of destructive pain relief treatments include the use of some chemicals, injection of a neurolytic substance, radiofrequency ablation, cryotherapy, denervation and use of a cryoprobe.

**PCSA2** has been retired following the addition of new codes and index entries in OPCS-4.11. A guidance box explaining how code assignment is determined in OPCS-4 has been added. Text also included to briefly describe the difference between destructive and non-destructive pain relief procedures. Further information can be found within Supplementary Information.

### **~~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)**~~

**PCSA3** retired and replaced by **PCSA9: Spinal and peripheral nerve neurostimulators (A46, A48, A70, A72)** and **PCSA10: Cranial nerve neurostimulators (A33)**

## 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** ([X57](#), [X65](#), [X67–X69](#))

**A10.7** is required to ensure these procedures are grouped into the correct [Healthcare Resource Group \(HRG\)](#).

### Example:

Stereotactic radiosurgery using [hypofractionated external beam](#) megavoltage [stereotactic treatment for trigeminal neuralgia](#)

#### **A10.7 Stereotactic radiosurgery on tissue of brain**

*Note: Use an additional code to specify radiotherapy delivery (~~X65~~[X69.6](#))*

#### ~~X65.4 Delivery of a fraction of external beam radiotherapy NEC~~

~~—————*Note: Use a subsidiary code to identify external beam radiotherapy (Y91)*~~

#### [X69.6 Delivery of a fraction of stereotactic external beam radiotherapy](#)

*Note: Use a subsidiary code to identify external beam radiotherapy (Y91)*

#### [Y91.5 Megavoltage treatment for hypofractionated stereotactic radiotherapy](#)

#### ~~Y91.1 Megavoltage treatment for complex radiotherapy~~

#### **Z03.5 Trigeminal nerve (v)**

Guidance box at **PCSA8** amended to display full text for HRG and example updated to reflect code assignment and notes in OPCS-4.11.

## PCSA10: Cranial nerve neurostimulators (A33)



[When a complete cranial nerve neurostimulator system is permanently implanted, the following codes and sequencing must be applied:](#)

#### [A33.1 Implantation of cranial nerve neurostimulator](#)

[Chapter Z site code, where this adds additional information](#)

#### [Z94.- Laterality of operation \(if applicable\)](#)

[A33.3 Removal of cranial nerve neurostimulator must only be assigned where the complete cranial nerve neurostimulator system is removed.](#)

[A complete neurostimulator system consists of a generator/battery, electrodes and leads/wires.](#)

**PCSA3** retired and replaced by **PCSA9: Spinal and peripheral nerve neurostimulators (A46, A48, A70, A72)** and **PCSA10: Cranial nerve neurostimulators (A33)**

### PCSA9: Spinal and peripheral nerve neurostimulators (A46, A48, A70, A72)



[When a spinal or peripheral nerve neurostimulator is permanently implanted, under the skin, the following codes and sequencing are applied:](#)

**[A48.3 Implantation of spinal cord neurostimulator or A70.1 Implantation of peripheral nerve 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:](#)

**[A48.7 Insertion of neurostimulator electrodes adjacent to the spinal cord or A70.4 Insertion of neurostimulator electrodes adjacent to peripheral nerve](#)**

**[Y70.5 Temporary operations](#)**

[Chapter Z site code, where this adds further information](#)

**[Z94.- Laterality of operation \(if applicable\)](#)**

[Spinal and peripheral nerve neurostimulators often involve a trial insertion of neurostimulator electrodes to ensure effectiveness of the treatment before permanent implantation takes place.](#)

#### **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](#)**

### **PCSA11: Nerve root excision (A58.2, A58.3)**

When more than one spinal nerve root has been excised, **A58.3 Excision of multiple spinal nerve roots** must be assigned, this includes:

- Multiple excisions at different levels of spine
- Bilateral nerve root excisions at the same level.

**A58.2 Excision of single spinal nerve root** must only be used when a single spinal nerve root has been excised (irrespective of level of spine).

See **PCSX34: Pelvic exenteration**

The excision of spinal nerve roots is sometimes performed as part of pelvic exenteration surgery, often alongside sacrectomy, excision of the obturator nerve and/or sciatic nerve. This is usually limited to the sacral nerve roots but may involve lumbar nerve roots in more complex procedures.

### **PCSA6: Evoked potential recording (A84.4)**

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

**PCSA6** has been retired as there are new codes for the specific types of evoked potential recordings that are assigned when these 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). Some patients may go on to have a Maintenance of wakefulness test (MWT) (U33.4) or Multiple sleep latency test (MSLT) (U33.5). ~~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 or Sleep Medicine and the emphasis will be on the diagnosis of ~~disorders of sleep~~ pattern disorders 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)

### 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 [endonasal](#) 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~~

[Y85.3 Endonasal endoscopic approach to organ](#)

**E15.8 Other specified operations on sphenoid sinus**

[Y85.3 Endonasal endoscopic approach to organ](#)

~~Y76.6 Endonasal endoscopic approach to other body cavity~~

**Y26.1 Reconstruction of organ NOC**

~~S28.8 Other specified flap of mucosa~~

[S28.2 Nasoseptal flap](#)

~~Y76.6 Endonasal endoscopic approach to other body cavity~~

[Y85.3 Endonasal endoscopic approach to organ](#)

~~Z22.6 Nasopharynx~~

See **PGCS1: Endoscopic and [percutaneous endoscopic procedures](#) ~~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.

[The Neurosurgery Expert Working Group has confirmed that a trans sphenoidal approach involves the opening of the nasoseptal area using an endoscope to allow access. It does not involve the opening of the cranium \(craniotomy\).](#)

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~~

**PCSB1** amended to reflect the new code for nasoseptal flap and endonasal approach code amended following the retirement of **Y76.6 Endonasal endoscopic approach to other body cavity** and further text added to the guidance section. Example deleted as no longer required.

#### ~~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**~~

Guidance retired following new notes being added to the OPCS-4 Tabular List at **B16.4**

#### ~~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~~

**PCSB3** has been retired due to the addition of a new combination code index entry for this procedure, in Section V of the Alphabetical Index



## CHAPTER C EYE (C01–C92)

### Chapter standards and guidance

#### PChSC1: Minimally invasive glaucoma surgery (MIGS)



When a procedure is documented as a MIGS procedure [Y77.3 Minimally invasive approach to organ](#) ~~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, [Y79](#) and [Y85](#))*

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

[Y77.3 Minimally invasive approach to organ](#)

~~Y76.9 Unspecified minimal access to other body cavity~~

**Z94.2** Right sided operation



## CHAPTER E RESPIRATORY TRACT (E01–E98)

### Coding standards and guidance

#### ~~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**~~

**PCSE1** has been retired because notes already exist in OPCS-4 at **E19.1**, **E19.2** and **E29.-**. Entries have also been added to Section V of the Alphabetical Index.

~~**PCSE2: Diagnostic fiberoptic 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 fiberoptic endoscopic examination of lower respiratory tract and lavage of lesion of lower respiratory tract**~~

~~Bronchoscopy with brushings:—~~

~~**E49.3—Diagnostic fiberoptic endoscopic examination of lower respiratory tract and brush cytology of lesion of lower respiratory tract**~~

~~Bronchoscopy with brushings and washings:—~~

~~**E49.4—Diagnostic fiberoptic 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 fiberoptic 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 fiberoptic 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 fiberoptic endoscopic examination of lower respiratory tract and biopsy of lesion of lower respiratory tract**~~

~~**Y21.8—Other specified cytology of organ NOC**~~

**PCSE2** has been retired due to the addition of specific index entries for each of the procedures listed within the standard. There have also been two new codes added to specifically classify bronchoscopy with biopsy and brushings, and bronchoscopy with biopsy and washings, therefore removing the need for a combination of codes to classify these procedures.

~~**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~~

PCSE3 has been retired as a new combination index entry has been added to Section V

#### 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** [see PCSE7: Ventilation support \(E85\) and ventilation initiation \(E96\)](#). ~~Codes within this category must always be assigned when ventilation support is performed in either an inpatient or outpatient setting.~~

PCSE4 title and standard exception text amended. New standard authored at PCSE7 instructing on the assignment of **E85** and **E96**. Examples also added to the new standard.

#### [PCSE7: Ventilation support \(E85\) and ventilation initiation \(E96\)](#)

[A code from category E85 Ventilation support must be assigned when ventilation support is performed in either an inpatient or outpatient setting. The exception is where ventilation support is performed as part of an initiation episode for long term ventilation where only a code from E96 Ventilation initiation must be assigned.](#)

[Ventilation initiation \(E96\) is carried out on patients for the purpose of achieving long term ventilation and will include a period of ventilation support.](#)

## Examples:

Patient diagnosed with obstructive sleep apnoea (OSA) admitted for planned continuous positive airway pressure (CPAP) initiation

### E96.1 Continuous positive airway pressure initiation

Patient with chronic obstructive pulmonary disease admitted with pneumonia with worsening oxygen levels started on CPAP

### E85.6 Continuous positive airway pressure

#### **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**~~

**E42.- Exteriorisation of trachea**

Adult patients in an Intensive Care Unit may have a temporary tracheostomy inserted for invasive ventilation but this would be very unusual in children.

A permanent tracheostomy (inserted as a surgical procedure) is typically created as part of the pathway for a child entering a home long-term invasive ventilation pathway (i.e. a child who is ventilator/respirator dependent).

**PCSE5** updated to allow for **E42.1 Permanent tracheostomy** to be assigned in addition to **E85.1** when a permanent tracheostomy is documented in the medical record.

#### **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 fiberoptic 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 (Y45–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**~~

~~Fiberoptic 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**~~

**PCSE6** retired as new index entries have been added to section V of the index.



## CHAPTER G UPPER DIGESTIVE TRACT (G01–G84)

### 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**~~

**PCSG1** has been retired due to the addition of a new combination code index entry for the procedure in Section V of the Alphabetical Index.

~~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.**~~

Guidance box retired following the addition of index entries into Section I of the OPCS-4 Alphabetical Index.

#### ~~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**~~

**PCSG2** retired following the addition of a new index entry to Section V of the OPCS-4 Alphabetical Index.

**~~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**~~

**PCSG6** retired following new index entries being added to Section V OPCS-4 Alphabetical Index.

**~~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**~~

**PCSG4** retired following new index entries being added to Section V OPCS-4 Alphabetical Index.



## CHAPTER H LOWER DIGESTIVE TRACT (H01–H74)

### Coding standards and guidance

## **PCSH6 Colonoscopy and flexible sigmoidoscopy (H20-H25, H38 and H39)**

When coding colonoscopy and flexible sigmoidoscopy procedures, a code from **H20-H25, H38 or H39** must be assigned based on the procedure documented, rather than the site of the colon reached.

- If a colonoscopy is documented, the procedure must be coded as a colonoscopy (**H20-H22, H38**), even if the examination is limited to the rectum, sigmoid or descending colon. This is an exception to ***PGCS3: Incomplete, unfinished, abandoned and failed procedures.***
- If a sigmoidoscopy is documented, the procedure must be coded as a sigmoidoscopy (**H23-H25, H39**), even if the examination extends past the sigmoid colon.

Where there is doubt as to whether a colonoscopy or sigmoidoscopy has been performed, clarification must be sought from the responsible consultant.

### See also:

- ***PGCS10: Coding endoscopic procedures***
- ***PCSH2: Colonoscopy with ileal intubation (H22.1)***

The distinction between a sigmoidoscopy and a colonoscopy relates to the extent of the large intestine (colon) examined and, consequently, the bowel preparation required.

A colonoscopy is a more comprehensive procedure designed to visualise the entire colon, from the rectum to the terminal ileum. Because a colonoscopy examines the full length of the colon, it requires more extensive bowel preparation to ensure a clear view. This procedure is also typically longer in duration.

A sigmoidoscopy is a more focused examination that only views the lower part of the large intestine (lower bowel), specifically the rectum and the sigmoid colon, and occasionally the descending colon. Due to this limited examination, it requires less extensive bowel preparation and is a shorter procedure.

### Examples:

*Colonoscopy report: A colonoscope was inserted via the anus to the distal sigmoid colon, insertion confirmed by images and limited by inadequate bowel preparation. Colonoscopy abandoned.*

**H22.9 Unspecified diagnostic endoscopic examination of colon during colonoscopy**

**Z28.6 Sigmoid colon**

Colonoscopy report: Bowel cancer screening. The intended extent of the examination was reached; the colon and terminal ileum were normal.

**H22.9 Unspecified diagnostic endoscopic examination of colon during colonoscopy**  
**Z27.6 Ileum**

Sigmoidoscopy report: A paediatric colonoscope was inserted via the anus to the sigmoid, insertion limited by faeces. Extensive sigmoid diverticular disease noted and biopsied.

**H25.1 Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel during flexible sigmoidoscopy**  
**Z28.6 Sigmoid colon**

Sigmoidoscopy report: Indication for examination - PR bleeding. Normal flexible sigmoidoscopy to the distal descending colon.

**H25.9 Unspecified diagnostic endoscopic examination of lower bowel during flexible sigmoidoscopy**  
**Z28.5 Descending colon**

#### **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**~~

**PCSH1** has been retired due to the addition of new combination code index entries in Section V of the Alphabetical Index.

#### **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 fiberoptic endoscopic examination of colon and biopsy of lesion of colon during colonoscopy**~~**Diagnostic fiberoptic 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 during flexible sigmoidoscopy](#)**  
~~**Diagnostic endoscopic examination of lower bowel and biopsy of lesion of lower bowel using fiberoptic sigmoidoscope**~~

**Z28.6 Sigmoid colon**

### **PCSH5: Video-assisted anal fistula treatment (VAAFT) (H55, H61 and Y85.8)**

The following codes must only be assigned when video-assisted anal fistula treatment (VAAFT) has been used to explore the anal fistula tract, and no further procedure is carried out:

**H55.8 Other specified other operations on perianal region**

**Y85.8 Other specified endoscopic approach to organ**

**Y31.1 Exploration of sinus tract from organ NOC**

If VAAFT proceeds to a therapeutic procedure on the anal fistula, **Y85.8 Other specified endoscopic approach to organ** must be assigned directly after the appropriate code for the anal fistula procedure (**H55 Other operations on perianal region** or **H61 Operations on perianal region**).

#### See also:

- [PGCS2: Diagnostic versus therapeutic procedures](#)
- [PCSY6: Approach to organ \(Y45–Y52, Y74–Y77, Y79 and Y85\)](#)

VAAFT utilises a fistuloscope for visualisation of the fistula tract on a monitor. A VAAFT procedure is normally performed in two stages (diagnostic and therapeutic). Both these stages are carried out during the same operation:

- In the diagnostic phase, the fistuloscope is inserted into the fistula to locate the internal opening in the anus and to identify any secondary tracts or abscess cavities.
- In the therapeutic phase of the procedure, the fistula tract is cleaned, and the internal opening of the fistula is sealed.

#### ~~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~~

**PCSH4** has been retired due to the addition of an Index entry in Section V. The 4<sup>th</sup> character for **Y51 Approach to organ through artificial opening into gastrointestinal tract** has not been specified in the index entry as the enema can be delivered through an appendicostomy, caecostomy or occasionally sigmoidostomy.

#### ~~Haemorrhoidal artery ligation (L70.3)~~

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

**PCSL2** has been retired as **H52.5 Ligation of haemorrhoidal artery** has been authored into OPCS-4.11.



## CHAPTER J OTHER ABDOMINAL ORGANS – PRINCIPALLY DIGESTIVE (J01–J78)

### Coding standards and guidance

### **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*~~

**PCSJ4** has been retired due to the addition of a new combination index entry in Section V of the Alphabetical Index

### **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).*~~

**PCSJ1** has been retired due to the addition of a new combination index entry in Section V of the Alphabetical Index. The use notes at **J12.3** and **X65.3** instruct on the additional codes required.



## CHAPTER K HEART (K01–K79)

### 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 4<sup>th</sup> 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 **Y77.4 Transluminal approach to organ through vein** ~~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~~**Y77.4** 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, Y79 and Y85)**
- **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~~percutaneous endoscopic approach 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~~ percutaneous endoscopic approach 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**

## 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**~~

**PCSK1** has been retired due to the addition of new entries in Section V of the Alphabetical index. Note that **Y77.4 Transluminal approach to organ through vein** has been authored into OPCS-4.11 and should be used for TAVI when performed via a percutaneous transluminal venous approach.

### ~~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~~

**PCSK11: Coronary angioplasty using fractional flow reserve**



When coronary angioplasty and/or insertion of stent(s) into the coronary artery/arteries are performed using fractional flow reserve (FFR) or pressure wire studies **K51.3 Percutaneous transluminal monitoring of pressure of coronary artery** must be coded in addition.

This is an exception to **PGCS2: Diagnostic versus therapeutic procedures**.

### **Examples:**

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

**K63.5 Coronary arteriography using single catheter**

Note: Use a supplementary code for measurement of fractional flow reserve (K51.3)

**Y53.9 Unspecified approach to organ under image control**

**K51.3 Percutaneous transluminal monitoring of pressure of coronary artery**

**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**

**Y53.4 Approach to organ under fluoroscopic control**

**K51.3 Percutaneous transluminal monitoring of pressure of coronary artery**

**Y53.4 Approach to organ under fluoroscopic control**

**PCSK3** retired and replaced with **PCSK11**. New code **K51.3** authored in OPCS-4.11 and new Tabular list notes added to codes in **K63**.

### ~~**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**~~

**PCSK5** has been retired due to the addition of new 4-character index entries in Sections I and III of the Alphabetical Index for VAD and LVAD procedures.

#### ~~**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**.~~

**PCSK6** retired following the addition of a note at **K58.6** in the OPCS-4 Tabular List. Information on the procedure has been added to OPCS-4 Supplementary Information.

#### ~~**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**.~~

**PCSK7** has been retired due to the addition of new inclusion terms and index entries for **K59.6** and **K59.7**. These additions clarify that the procedure codes are applicable to CRT-D devices with either two or three leads.

#### ~~**Evaluation of cardioverter defibrillator (X50.5)**~~

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

**PCSX15** retired following the addition of a new note at **X50.5** in the OPCS-4 Tabular List.

### PCSK10: Renewal of pacemaker generator/battery (~~K70.-, 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.~~

The renewal of a pacemaker generator/battery must be coded to a specific renewal of pacemaker code from **K70.- Leadless cardiac pacemaker system introduced through vein**, **K73.- Other cardiac pacemaker system introduced through vein** or **K74.- Cardiac pacemaker system**, when the type of pacemaker is known.

**K60.3 Renewal of intravenous cardiac pacemaker system NEC** and **K61.3 Renewal of cardiac pacemaker system NEC** must only 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 **K70.-, K73.- and K74.-** must be used as there is a significant resource difference between these renewal procedures.

PCSK10 has been updated to include new leadless pacemaker codes and update language.

### 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**~~

**PCSK9** has been retired as there is now a specific code to classify lithotripsy of coronary artery at **K50.6 Percutaneous transluminal lithotripsy of coronary artery**. Notes have also been added to instruct on the assignment of additional codes (**K49** and **K75**).



## CHAPTER L ARTERIES AND VEINS (L01–L99, O01–O05, O15, O20, O54, O56)

### Coding standards and guidance

#### ~~**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**~~

**PCSL2** has been retired as **H52.5 Ligation of haemorrhoidal artery** has been authored into OPCS-4.11.

#### ~~**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~~

**PCSL3** has been retired due to the addition of a new combination index entry for the procedure in Section V of the Alphabetical index.

#### **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~~

**PCSL4: Fistuloplasty of arteriovenous fistula (L74.3)** has been retired as there is now a specific code to classify fistuloplasty of an arteriovenous fistula at **O54.1 Percutaneous transluminal balloon fistuloplasty of arteriovenous fistula**.

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



##### Operations on varicose perforator veins

Varicose vein codes that are specific to the saphenous vein must not be used to classify procedures on varicose perforator veins. A non-site-specific code must be used instead, with the site code **Z98.8 Specified vein of lower limb NEC**.

When concurrent procedures are performed on the leg perforator vein(s), they must be coded in addition to the procedures on the saphenous vein(s).

##### Combined operations on varicose veins

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.

The following codes must be assigned when any combination of ligation, stripping or avulsion of the leg perforator veins, described in L85 and L87, are performed at the same time:

L84.8 Other specified combined operations on varicose vein of leg  
Z98.8 Other specified vein of lower limb  
Z94.- Laterality of operation

**Example:**

*Stripping and avulsion of right recurrent long saphenous vein with ligation of right perforator veins*

**L84.4 Combined operations on recurrent long saphenous vein**  
L85.8 Other specified ligation of varicose vein of leg  
Z98.8 Other specified vein of lower limb  
**Z94.2 Right sided operation**

*Ultrasound guided foam sclerotherapy to long saphenous varicose vein and perforator veins left leg*

L86.2 Ultrasound guided foam sclerotherapy for varicose vein of leg  
Z98.5 Long saphenous vein  
Z98.8 Specified vein of lower limb NEC  
Z94.3 Left sided operation

**PCSL5** updated to include instructions on how to capture procedures on varicose perforator veins. Example amended and new example added.

**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.~~

**PCSL7** has been retired following the addition of includes notes at codes in category **O01.-** within the OPCS-4.11 Tabular List



## CHAPTER M URINARY (M01–M92)

### 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.~~

**PCSM1** has been retired due to the new note at **M13.2 Percutaneous drainage of kidney** which prohibits the addition of an additional code classifying the insertion of a nephrostomy tube.

#### ~~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**~~

**PCSM12** has been retired due to the addition of new index entries for ‘cystoscopic cystodiathermy’ and ‘endoscopic cystodiathermy’. **PGCS20: Procedures performed for haemostasis** provides instruction on the coding of coagulation and/or cauterisation when performed as a means of haemostasis throughout OPCS-4.

#### ~~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**~~

**PCSM8** retired due to new note added at **M66** in the OPCS-4.11 Tabular List and new index entries added to Section I, Section III and Section V of the OPCS-4.11 Alphabetical Index.

#### ~~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).**~~

**PCSM9** has been retired as there are existing notes within OPCS-4 which indicate the codes to assign for this procedure. New entries have also been added to Section V of the Alphabetical index which also account for variation in dose rates.

~~**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.~~

Guidance moved into Supplementary Information

#### ~~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.**~~

**PCSM10** retired due to the addition of an index entry to Section V of the OPCS-4.  
Alphabetical Index



## 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**~~

**PCSN1** retired following the addition of new entries into Section I of the OPCS-4  
Alphabetical Index.



## CHAPTER P LOWER FEMALE GENITAL TRACT (P01–P33)

### Chapter 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**~~

**PCSP1** retired following addition of new index entries to Section V of the OPCS-4  
Alphabetical Index.

### PCSP3: Episiotomy to facilitate delivery of terminated ~~fetus~~ pregnancy or late miscarriage and subsequent repair (P14.9, P13.2, P25.5)

Where an episiotomy (**P14.9 Unspecified incision of introitus of vagina**) is carried out to facilitate delivery of a terminated ~~fetus~~ pregnancy, or late miscarriage, this must be sequenced in a secondary position to the delivery code (**Q58 Delivery of terminated pregnancy** or **Q59 Delivery of late miscarriage**).

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 pregnancy (Q58), or late miscarriage (Q59)**

PCSP3 amended to reflect the updated terminology at category **Q58 Delivery of terminated pregnancy** and the new category at **Q59 Delivery of late miscarriage**.



## CHAPTER Q UPPER FEMALE GENITAL TRACT (Q01–Q63)

### 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**~~

**PCSQ1** retired following the addition of paired code notes into the OPCS-4 Tabular List.

**~~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.~~

**PCSQ2** has been retired as notes have been added to **Q10 Curettage of uterus**, **Q12 Intrauterine contraceptive device** and **Q18 Diagnostic endoscopic examination of uterus** along with new index entries. Guidance moved to supplementary information.

#### ~~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**~~

**PCSQ3** retired following the amendment of the notes at **Q13.1**, **Q21.1** and **Q38.3** instructing the addition of codes from **Y96** demonstrating the type of fertilisation used.

#### ~~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**~~

**PCSQ4** retired following the addition of new index entries into Section V of the OPCS-4 Alphabetical Index.

The codes in category **Q58 Delivery of terminated fetus-pregnancy** and **Q59 Delivery of late miscarriage** are for use when it is documented in the medical record that the responsible consultant (for example a midwife) has 'delivered' a [fetus following a medically terminated fetus-pregnancy](#) (which may be liveborn or showing no signs of life), [or a late miscarriage](#). The delivery of a terminated fetus is generally performed for late termination of pregnancy.

[A late miscarriage is a spontaneous loss of pregnancy from 13 up to and including 23+6 weeks gestation.](#)

It is strongly recommended that coding managers work closely with the responsible consultants to ensure codes in category **Q58** and **Q59** 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-pregnancy**  
**Y95.1 Over 20 weeks gestational age**  
**Q14.5 Insertion of prostaglandin pessary**  
**Y95.1 Over 20 weeks gestational age**

[Patient admitted for a medically induced \(prostaglandin pessary\) termination of pregnancy at 16 weeks gestation. The fetus was delivered \(in breech position\) by the consultant.](#)

[Q58.2 Breech delivery of terminated pregnancy](#)  
[Y95.2 From 14 weeks to 20 weeks gestational age](#)  
[Q14.5 Insertion of prostaglandin pessary](#)  
[Y95.2 From 14 weeks to 20 weeks gestational age](#)

[Patient admitted with spontaneous miscarriage at 13+2 weeks gestation. The fetus was delivered \(in cephalic position\) without complication.](#)

[Q59.1 Cephalic delivery of late miscarriage](#)  
[Y95.3 From 9 weeks to < 14 weeks gestational age](#)

Guidance box has been updated to reflect the introduction of a new category for delivery of late miscarriage, updated terminology at category **Q58** and examples added to aid coder understanding.

### PCSQ5: Genital swab (Q55.6)

The code **Q55.6 Genital swab** must only be used ~~for outpatient coding~~ [in an outpatient setting](#), or [if/when](#) the patient is admitted solely for the purpose of this procedure.

**PCSQ5** amended to confirm that **Q55.6** must only be assigned in an outpatient setting or when the patient is admitted solely for the purpose of the procedure



## CHAPTER R FEMALE GENITAL TRACT ASSOCIATED WITH PREGNANCY, CHILDBIRTH AND PUERPERIUM (R01–R44)

### Chapter standards and guidance

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

The guidance box in Chapter R has been retired as the notes at chapter level clearly state where miscarriage and terminations are classified.

### PChSR1: Coding deliveries (R17-R25)



All deliveries (except delivery following a termination of pregnancy (**Q58**) [or late miscarriage \(Q59\)](#)), 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) [or late miscarriage \(Q59\)](#).**

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:

[Normal vaginal delivery of stillbirth at 25 weeks gestation](#)

#### [R24.9 All normal delivery](#)

**PChSR1** has been updated to reflect the introduction of a new category for delivery of late miscarriage in Chapter Q and a change to the terminology in category **Q58**. An additional example has been added to aid coder understanding

### 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.**~~

**PCSR1** has been retired as specific index entries and new codes have been authored in OPCS-4.11 to classify ARM procedures.

### **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.~~

**PCSR2** has been retired as there are now dedicated codes within category **R16 Augmentation of labour** to classify this procedure. Codes have also been added at category **Q61 Augmentation of labour for delivery of late miscarriage or terminated pregnancy**.

### **PCSR7: Obstetric scans (R36-R43)**

Codes within categories **R36–R43** must only be used ~~for day cases and inpatients in an outpatient setting or~~ 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)**~~ **PCSU1: [Diagnostic imaging procedures \(U01–U18, U20–U21, U35–U37 and U42\)](#)**.

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

**PCSR7** amended to confirm that codes from **R36-R43** must only be assigned in outpatients or where the patient is admitted solely for the purpose. Corresponding text removed from **PCSU1**.



## CHAPTER S SKIN (S01–S70)

### Coding standards and guidance

~~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.~~

Guidance box retired following the addition of new index entries into Section I of the OPCS-4.11 Alphabetical Index.

#### PCSS5: Debridement and washout of skin and wounds



#### Examples:

~~*Debridement and **P**primary suture ~~to~~of 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



## CHAPTER T SOFT TISSUE (T01–T98)

### 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**.~~

**PCST1** retired following the addition of new index entries to Section V of the OPCS-4 Alphabetical Index.

#### **PCST2: Release of trigger finger (T72.3)**

~~Release of trigger finger must be coded using **T72.3 Release of constriction of sheath of tendon.**~~

**PCST2** has been retired as new index entries have been added to Section V of the Alphabetical Index.

#### **PCST4: Anterior abdominal wall reconstruction for hernia repair (T32)**



When an abdominal wall hernia (incisional, parastomal or ventral) is repaired using abdominal wall reconstruction (involving some form of myofascial release) a code from **T32 Reconstruction of anterior abdominal wall** must be assigned. A separate hernia repair code must not be assigned in addition.

Where there is any doubt that abdominal wall reconstruction has been performed clarification must be sought from the responsible consultant using the definitions provided in the guidance box.

If mesh and/or scaffold has been used a code from **Y28 Insertion of other material into organ NOC** and/or **Y36 Introduction of non-removable material into organ NOC** must be assigned in addition to the code from **T32**.

Where there is any doubt regarding the type of mesh or scaffold that has been used clarification must be sought from the responsible consultant.

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

Myofascial release in abdominal wall reconstruction refers to surgical techniques that free or divide specific layers of the abdominal wall musculofascial system to allow tension-free closure of large midline defects.

The following procedures are considered forms of myofascial release and are an indication of abdominal wall reconstruction:

- Rives-Stoppa
- Anterior Component Separation (ACS)
- Transversus Abdominis Release (TAR)
- Posterior Component Separation (PCS)

Other indications of abdominal wall reconstruction within the operation note include, but are not limited to:

- Retrorectus mesh
- Retromuscular mesh

An abdominal hernia repair would **not** be classified as abdominal wall reconstruction if it employs techniques that focus on a simple suture repair, bridging the defect or using simpler fascial closure, rather than involving a myofascial release.

### **Examples:**

Laparotomy and extensive adhesiolysis. Repair of complex abdominal wall hernia requiring bilateral transverse abdominis release, re-enforced with a synthetic absorbable tissue re-enforcement scaffold and permanent synthetic polyvinylidene fluoride (PVDF) mesh. 2-0 PDS small bites closure with partial anterior fascial apposition. A 5cm fascial gap remained so the fascial edges were sutured to the mesh circumferentially with 2-0 prolene and the peritoneal flap was then secured across to cover the mesh with 2-0 PDS.

**T32.4 Reconstruction of anterior abdominal wall using insert of prosthetic material and flap NEC**

**Y28.1 Insertion of synthetic mesh into organ NOC**

**Y36.6 Introduction of synthetic scaffold into organ NOC**

**T41.5 Freeing of extensive adhesions of peritoneum**

Rives-Stoppa repair of incisional hernia with placement of permanent polypropylene mesh in the retrorectus space to provide robust, tension-free reinforcement.

**T32.2 Reconstruction of anterior abdominal wall using insert of prosthetic material**

**Y28.1 Insertion of synthetic mesh into organ NOC**

Laparotomy, repair of parastomal hernia and incisional hernia with intraperitoneal onlay mesh (IPOM) using Reinforced Tissue Matrix (RTM). Responsible consultant confirmed this was a biosynthetic tissue re-enforcement scaffold.

**T25.2 Primary repair of incisional hernia using insert of prosthetic material**

**Y36.7 Introduction of other scaffold into organ NOC**

**PCST3: Sampling, excision, biopsy or drainage of sentinel lymph node (T86-T88, T91.1 and O14.2) and targeted lymph node dissection (T84.1)**

When sampling, excision, biopsy or drainage of sentinel lymph node is performed the following codes must be assigned:

**T86-T88**

**[Y45.5 Approach to organ under marker guided control NEC](#)**

**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.

[When targeted lymph node dissection \(T84.1 Targeted excision of lymph node\) is performed at the same time as a sentinel lymph node biopsy, codes classifying both procedures must be assigned. This is an exception to PGCS2: Diagnostic versus therapeutic procedures.](#)

**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)*

**[Y45.5 Approach to organ under marker guided control NEC](#)**

**Y68.1 Approach to organ under contrast enhanced ultrasonic control**

**O14.2 Sentinel lymph node**

**Z94.2 Right sided operation**

[Targeted axillary dissection \(TAD\) under marker guided control following sentinel lymph node biopsy of left breast.](#)

**[T84.1 Targeted excision of lymph node](#)**

*Note: Use an additional code to identify concurrent biopsy of sentinel lymph node (T87)*

**[Y45.5 Approach to organ under marker guided control NEC](#)**

**[Z61.3 Axillary lymph node](#)**

**[Z94.3 Left sided operation](#)**

**[T87.3 Excision or biopsy of axillary lymph node](#)**

*Note: Use subsidiary code for sentinel lymph node (O14.2)*

**[Y45.5 Approach to organ under marker guided control NEC](#)**

**[O14.2 Sentinel lymph node](#)**

**[Z94.3 Left sided operation](#)**

**PCST3** has been updated to include the code for approach to organ under marker guided control, and to provide instruction relating to the coding of targeted lymph node dissection.

### 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.~~

Guidance retired following new note being added to the OPCS-4 Tabular List at **T91.2**.



## CHAPTER U DIAGNOSTIC IMAGING, TESTING AND REHABILITATION

(U01–U54)

### Coding standards and guidance

#### PCSU1: Diagnostic imaging procedures (U01–~~U21~~ U18, U20–U21, and U34 U35–U37 and U42)

##### 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** NEC, **C87.1 Digital imaging of retina** NEC and scanning codes within the range **R36–R43**, the body system chapter code **must** be used in preference to the diagnostic imaging codes within ~~categories U01–U21 and U34–U37~~ Chapter U.

~~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** 18 and **U20–U21** and their extended categories **U34** U35–U37 and U42 **are** must only ~~for~~ be used in an outpatient setting, or ~~if a~~ when the 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)**
- [U17.7 Wireless capsule endoscopy of digestive tract](#)
- **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~~ [diagnostic imaging codes in Chapter U](#) 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~~ [diagnostic imaging codes in Chapter U](#) that classify nuclear medicine imaging procedures do not require the addition of codes from categories **Y97** or **Y98** [unless there is a note at code level instructing otherwise](#) – 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~~are **PCSU8: Cardiac computed tomography for calcium scoring and cardiac computed tomography angiography (U10.2)**, ~~and~~ **PCSU9: Bone densitometry (U13.1)** and PCSU11: Vascular ultrasound scans.

#### **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. These will be corrected in the next version of OPCS-4.~~

**PCSU1** amended to mirror the categories listed at diagnostic imaging in Section I of the OPCS-4 Tabular List. **U17.7** included specifically within the standard. Text relating to the coding of SPECT-CT and PET-CT deleted due to notes being added to the relevant codes in the Tabular List. Guidance box deleted. **U17.7** added to the list of diagnostic imaging codes excluded from **PCSU1**. Text relating to the coding of diagnostic imaging amended for a consistent approach across standards to state that these codes must only be used in an outpatient setting or when the patient has been admitted solely for the purpose of a procedure/intervention.

## PCSU2: Radiological contrast and body areas (Y97-Y98)

The 'Notes' at ~~categories U01–U21 and U34–U37~~ [diagnostic imaging codes in Chapter U](#) 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 [diagnostic imaging](#) codes in ~~categories U01–U21~~ [Chapter U unless there is a specific instruction to do so](#) – 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.

### PCSU3: Nuclear medicine imaging procedures (~~U01–18, U20–U21, and U34~~ **U35–U37 and U42**)

Nuclear medicine imaging codes in ~~the range U01–U21 and their extended categories U34–U37~~ **Chapter U** ~~are only for use in an outpatient setting, or if a patient must only be used in an outpatient setting or when the patient~~ has been admitted solely for the purpose of a nuclear medicine imaging procedure. The exceptions to this standard are:

- **Positron ~~e~~Emission ~~t~~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~~ **in Chapter U** 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** ~~as indicated by the notes within the tabular list~~, 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 [any other](#) nuclear medicine [imaging](#) codes ~~in categories **U01-U21**, see *PCSU1 Diagnostic imaging procedures (U01-U18, U20-U21 and U34, U35-U37 and U42)* 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.~~

[There are two nuclear medicine imaging procedures available in the main body system chapters. These are \*\*B16.4 Parathyroid washout\*\* and \*\*T91.2 Scanning of sentinel lymph node\*\*.](#)

#### 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)*

[Use subsidiary codes to identify radiology with contrast \(Y97\), radiology procedures \(Y98\)](#)

#### **Y94.8 Other specified radiopharmaceutical imaging**

#### **Y98.1 Radiology of one body area (or < 20 minutes)**

#### **Z30.1 Liver NEC**

**PCSU3** amended following the addition of notes at **U36.2** and **U36.3** in the OPCS-4 Tabular List. Text deleted from the standard following addition of notes and **B16.4** and **T91.2** and text added to the guidance box confirming that these nuclear medicine imaging codes are located outside of Chapter U.

### **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~~ [must only be used](#) in an outpatient setting, or ~~for day cases and inpatients if a~~ [when the](#) 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 and classification of epilepsy and non-epileptic attack disorders, ~~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 EEG telemetry involved continuous recording of EEG over a minimum of 24 hours but can be significantly longer. This can be with or without simultaneous video telemetry is recorded continuously for the entire length of stay recording of the patient. 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).**

Guidance updated following clinical input and language updated within **PCSU5** to align with other standards.

Studies for Ssleep disorders involving respiratory functions, such as sleep apnoea, are classified at code U33.1 Polysomnography. ~~They are~~ normally conducted by a specialist Respiratory team using ~~polysomnography or~~ cardiopulmonary sleep studies which uses 3 or more types of sensors (known as “channels”) but without electroencephalography. ~~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).**

#### 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~~ must only be used 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.

**PCSU4** amended to align language used across standards.

## **PCSU11: Vascular ultrasound scans**

The codes classifying vascular ultrasound must only be used in an outpatient setting or if the patient has been admitted solely for the purpose of a procedure/intervention.

When coding vascular ultrasound scans one of the following codes must be assigned, regardless of the number of body areas scanned, or if performed concurrently with another scan on the same body area:

**U11.1 Ultrasound of carotid artery**

**U11.2 Doppler ultrasound of vessels of extremities**

**U11.3 Vascular ultrasound NEC**

**U35.2 Laser Doppler ultrasound velocimetry**

**U35.3 Transcranial Doppler ultrasound velocimetry**

U21.6 Ultrasound scan NEC must not be used to classify these procedures; the coding of vascular ultrasound scans is an exception to **PCSU1: Diagnostic imaging procedures (U01-U18, U20-U21, U35-U37, U42)**. Vascular ultrasound scans must be coded in addition to other types of scans using one of the codes above.

See also **PCSU2: Radiological contrast and body areas (Y97-Y98)**.

### **Example:**

Patient admitted for bilateral carotid artery ultrasound scan (8-minute duration) and CT scan of cerebral vessels with pre and post contrast.

**U11.1 Ultrasound of carotid artery**

*Note: Use subsidiary codes to identify radiology with contrast (Y97), radiology procedures (Y98)*

**Y98.1 Radiology of one body area (or < 20 minutes)**

**Z94.1 Bilateral operation**

**U11.4 Computed tomography scan of cerebral vessels**

*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)**

The use of the specific vascular ultrasound codes listed in **PCSU11** are required to generate the correct vascular ultrasound healthcare resource group (HRG).



## CHAPTER V BONES AND JOINTS OF SKULL AND SPINE (V01–V71)

### Coding standards and guidance

#### ~~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~~

**PCSV1** retired following the authoring of new codes at **V71** to classify both partial and total excision of bone of cranium and addition of index entries for temporal bone and petrous bone.

#### ~~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~~

**PCSV2** has been retired and added to the Alphabetical Index of Surgical Eponyms

~~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 Champney plates, screws and plates. **V17.3 Extraoral fixation of mandible** includes outside splints, such as halo.~~

Guidance box retired as new index entries having been added to Section I of the OPCS-4.11 Alphabetical Index directing coders to the appropriate codes.

~~**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.~~

**PCSV4** retired following addition of a note in the OPCS-4 Tabular List and a new index entry into Section V of the OPCS-4 Alphabetical Index.

~~**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.~~

**PCSV5** retired following the addition of new index entries to both Section I and Section III of the Alphabetical Index. **PCSV8** authored instructing that **V40.4** must not be assigned in addition to lumbar interbody fusion 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.~~

The guidance box in relation to assigning codes from **V40** has been retired due to new includes notes added at category level in the Tabular List.

#### **PCSV8: Instrumented lumbar fusion (V40.4)**

When a lumbar interbody fusion procedure has been performed and the fusion is documented as instrumented; code **V40.4 Posterior instrumented fusion of lumbar spine NEC** must not be assigned in addition.

Instrumented lumbar fusion including the use of cages, screws rods and plates is an integral part of a lumbar interbody fusion.

#### **Example:**

*L4/L5 posterior lumbar interbody fusion using graft and cage with concurrent posterior instrumented fusion of L4/L5 using pedicle screws and rods.*

**V38.5 Primary posterior interbody fusion of joint of lumbar spine**

**V55.1 One level of spine**

#### ~~**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 NOG**~~

~~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.~~

**PCSV6** has been retired as a new index has been added to Section V of the OPCS-4 Alphabetical Index. The guidance has been retained in the OPCS-4 Supplementary Information.

#### **PCSV7: Spinal fracture procedures (V44, V45 and V46)**

Where a specific code(s) for a procedure(s) performed for a spinal fracture does not exist within **V44 Decompression of fracture of spine**, **V45 Other reduction of fracture of spine** or **V46 Fixation of fracture of spine** but there is a specific code(s) elsewhere within Chapter V, this code(s) must be assigned instead.

The code(s) assigned must fully and accurately reflect the procedure(s) performed. Where there is any uncertainty regarding the specific procedure(s) carried out, advice must be sought from the responsible consultant

The use of a combination of ICD-10 and non-fracture-specific OPCS-4 codes from Chapter V provides a more comprehensive classification of spinal fracture procedures than relying on **V44**, **V45**, and **V46** alone.

#### **Examples:**

*Posterior stabilisation of L2 fracture using screws under image intensifier guidance*

**V46.6** Fixation of fracture of spine using screw

**V55.1** One level of spine

**Y53.5** Approach to organ under image intensifier

**Z66.5** Lumbar vertebra

*Patient with a C5 fracture underwent a primary anterior corpectomy of C5 with reconstruction using cage*

**V22.4** Primary anterior corpectomy of cervical spine with reconstruction HFQ

**V55.1** One level of spine

### Pain relief procedures

For the standard for the coding of facet joint block ~~see **PCSA2: Pain relief procedures.**~~

[See Chapter A for guidance on the classification of pain relief procedures.](#)

**PCSA2** retired reference to the standard replaced with guidance box in Chapter V.



## CHAPTER W OTHER BONES AND JOINTS

(W01–W99, O06–O10, O17–O19, O21–O27, O29, O32, O35, O37–O41, O49, O51, O55)

### Chapter standards and guidance

#### PChSW2: Arthroscopic procedures (W84.8)

For procedures performed arthroscopically, code **W84.8 Other specified therapeutic percutaneous endoscopic operations on other joint structure** ~~Other specified therapeutic endoscopic operations on other joint structure~~ must only be assigned when:

- There is no specific 4<sup>th</sup> character percutaneous endoscopic (arthroscopic) code that classifies the procedure
- There is no specific 4<sup>th</sup> character open code that classifies the procedure
- There is no **.8 Other specified** code in any other percutaneous endoscopic or open category that describes the organ or structure on which the procedure is performed

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

#### PChSW4: Coding bone grafts

When a bone graft (of bones other than skull and spine) is performed, a code from **W31 Other autograft of bone, O55 Autograft of bone or W32 Other graft of bone** must be assigned to classify the type of bone graft. This includes where another body system code already identifies a bone graft or is an HFQ code (this is an exception to **PConvention 3: Abbreviations**).

**Autograft of bone must be coded as follows:**

- **W31 Other autograft of bone or O55 Autograft of bone**
- **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 being grafted**
- **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 site of the harvest (if this has not already been identified within the Y harvest code)**
- **Z94.- Laterality of operation (if applicable).**

The exception to this standard is **PCSW4: Total hip replacement with acetabular bone graft (W37-W39)**, as it may not always be necessary to code an acetabular bone autograft.

**Examples:**

**Primary open reduction and internal fixation of left distal radius using plate, bone defect filled using morcellised autograft harvested from left iliac crest.**

**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**  
**W31.4 Cancellous chip autograft of bone**  
**Z70.5 Lower end of radius NEC**  
**Z94.3 Left sided operation**  
**Y66.3 Harvest of bone from iliac crest**  
**Z94.3 Left sided operation**

**Primary fusion of left ankle joint using screws and bone allograft to talus bone**

**W60.1 Primary arthrodesis and extra-articular bone graft NEC**  
**Z85.6 Ankle joint**  
**Z94.3 Left sided operation**  
**W32.2 Allograft of bone NEC**  
**Z79.1 Talus**  
**Z94.3 Left sided operation**

**Curettage of enchondroma of phalanx of right thumb. Bone allograft used to fill the defect**

[W09.5 Curettage of tumour of bone and graft HFQ](#)

[Z73.3 Phalanx of thumb](#)

[Z94.2 Right sided operation](#)

[W32.2 Allograft of bone NEC](#)

[Z73.3 Phalanx of thumb](#)

[Z94.2 Right sided operation](#)

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.~~

Intramedullary fixation guidance moved to new coding standard **PCSW16**

## Coding standards and guidance

~~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.~~

Guidance box retired as new excludes note authored at **W08.7** in OPCS-4.11 directing coders to Chapter D for operations on ossicles of the ear.

### **PCSW16: Open reduction of fracture of bone and intramedullary fixation (W19)**

The following codes in **W19 Primary open reduction of fracture of bone and intramedullary fixation** must be used if the code description fully describes the procedure performed, even if the type of fixation is **not** 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**

**W19.5 Primary open reduction of fragment of bone and fixation using screw**

**W19.6 Primary open reduction of fragment of bone and fixation using wire system**

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.

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** (which classify procedures that are not

[considered intramedullary\) should continue to be used where the four-character code description reflects the procedure documented within the medical record.](#)

### **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~~

**PCSW2** has been retired due to the addition of a new index entry in Section V of the Alphabetical Index

### **PCSW4: Total hip replacement with acetabular bone graft (W37-W39) [and](#) [implantation of augmentation prosthesis \(O09.2\)](#)**



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** [or O55.- Autograft 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**

[Where a graft augmentation prosthesis is implanted into an acetabular bone defect concurrently with a total hip replacement procedure, the following codes must be assigned in addition:](#)

[O09.2 Implantation of augmentation prosthesis into defect of bone](#)

[Z75.6 Acetabulum](#)

[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:

*Revisional uncemented left total hip replacement with morcellised autograft of bone to fill large acetabular defect [and implantation of a porous augmentation prosthesis into a severe 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  
[O09.2](#) [Implantation of augmentation prosthesis into defect of bone](#)  
[Z75.6](#) [Acetabulum](#)  
**Z94.3** Left sided operation

**PCSW4** updated to include the use of graft augmentation prostheses during total hip replacement using new OPCS-4.11 code **O09.2**.

### ~~PCSW6: Unicompartamental knee replacement (W58.1)~~



~~Unicompartamental 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~~

**PCSW6** retired following the addition of a note at **W58.1** in the OPCS-4 Tabular List and new index entries in Section V of the OPCS-4 Alphabetical Index.

### 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 Percutaneous endoscopic stem cell implantation into articular cartilage**  
~~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*).

#### ~~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**~~

**PCSW7** has been retired due to the addition of a new eponym in the Alphabetical Index. These procedures are coded in line with **PRule8: Surgical eponyms**, which has also been updated, and **PGCS1: Endoscopic and percutaneous endoscopic procedures that do not have a specific code**.

#### ~~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** [Percutaneous endoscopic harvest of autologous chondrocytes](#) ~~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** [Percutaneous endoscopic autologous chondrocyte implantation of knee joint](#) ~~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.~~

**PCSW9** retired following the addition of excluded notes into the OPCS-4 Tabular List and a new index entry being added to Section I of the OPCS-4 Alphabetical Index.

### 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 Percutaneous endoscopic decompression of joint ~~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 Percutaneous endoscopic decompression of joint ~~Endoscopic decompression of joint~~**

**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. Lateralities 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.~~

**PCSW11** has been retired as notes already exist in OPCS-4 at **O18.1**. Entries have also been added to Section V of the Alphabetical Index.

#### **PCSW15: Sacrectomy (O29.2, O29.3, O29.4)**

Excision of part of the sacrum (sacrectomy) must be coded whenever performed. Code assignment will depend on the extent of the sacrum excised, with only the most extensive type of sacrectomy being coded.

**O29.2 High subcortical sacrectomy (least extensive)**

**O29.3 Low sacrectomy**

[O29.4 High sacrectomy \(most extensive\)](#)

[See also PCSX34: Pelvic exenteration](#)



## CHAPTER X MISCELLANEOUS OPERATIONS (X01–X98)

### Coding standards and guidance

#### PCSX32: Cytoreductive surgery (X13.1)



[X13.1 Cytoreductive surgery](#) must be assigned when [cytoreductive surgery is documented to have been carried out](#).

[As cytoreductive surgery involves the resection of multiple tissues and organs, codes for these procedures must be assigned following X13.1.](#)

#### Example:

[Open cytoreductive surgery after neoadjuvant chemotherapy for stage 4 high grade serous ovarian cancer with extensive peritoneal adhesiolysis, en bloc resection of the left ovary and fallopian tube, anterior resection of part of the rectum and sigmoid colon with primary stapled anastomosis. Resections of the posterior peritoneum, omentectomy, incidental appendectomy and resection of lesion from pouch of Douglas.](#)

#### [X13.1 Cytoreductive surgery](#)

[Note: Code in addition the specific organ or tissue resection procedures](#)

#### [Q23.1 Unilateral salpingoophorectomy NEC](#)

#### [Z94.3 Left sided operation](#)

#### [H02.4 Incidental appendectomy](#)

#### [T41.5 Freeing of extensive adhesions of peritoneum](#)

#### [T41.6 Excision of peritoneum](#)

#### [T36.1 Omentectomy](#)

#### [H33.3 Anterior resection of rectum and anastomosis of colon to rectum using staples](#)

#### [P31.7 Extirpation of lesion of pouch of Douglas](#)

## PCSX34: Clearance of pelvis (X14)



### Pelvic exenteration

A code from X14.1-X14.3 must only be assigned when pelvic exenteration is documented to have been carried out.

Codes for the associated resection and reconstruction procedures must be assigned in addition; these codes may be sequenced in any order providing they are all sequenced following X14.1-X14.3 and adhere to other National Clinical Coding Standards as appropriate.

### Pelvic sidewall clearance

If pelvic side wall clearance is performed in addition to pelvic exenteration, X14.4 Pelvic side wall clearance must be coded in addition to X14.1-X14.3, in any secondary position.

X14.4 includes resection of the internal iliac artery and vein. If other veins and/or arteries (such as the common iliac vessels) are resected, these must be coded in addition

### See also:

- PCSA11: Nerve root excision (A58.2, A58.3)
- PCSW15: Sacrectomy (O29.2, O29.3, O29.4)

Pelvic exenteration surgery involves the resection and reconstruction of multiple tissues and organs.

### Example:

Total pelvic exenteration involving total cystectomy, extra-levator abdominoperineal excision (ELAPE), total abdominal hysterectomy, bilateral salping-oophorectomy, pelvic sidewall clearance and low sacrectomy. Total vaginectomy and further pelvic block dissection of lymph nodes was also performed. End colostomy formation was performed following the ELAPE. Segment of ileum excised for ileal conduit formation. Vaginal reconstruction using pelvic peritoneum and perineal reconstruction using superior gluteal artery perforator flap (SGAP) were used to reapproximate anatomy and close defects.

X14.1 Total exenteration of pelvis

H45.1 Extralevator abdominoperineal excision of rectum and end colostomy

P12.3 Reconstruction of female perineum using gluteal artery perforator flap

X14.4 Pelvic side wall clearance

O29.3 Low sacrectomy

M34.3 Cystectomy NEC

M19.1 Construction of ileal conduit

[Q07.4 Total abdominal hysterectomy NEC](#)

[Q22.1 Bilateral salpingoophorectomy](#)

[P17.1 Total colectomy](#)

[P32.2 Reconstruction of vagina using pelvic peritoneal graft](#)

[T85.6 Block dissection of pelvic lymph nodes](#)

### **PCSX33: Gender affirmation procedures (X15)**

[Code X15.1 Combined operations for transformation from male to female or X15.2 Combined operations for transformation from female to male must be assigned whenever gender affirmation procedure\(s\) have been documented to have been carried out.](#)

[Codes from the body system chapters that describe the specific procedure\(s\) performed must also be assigned and sequenced following X15.1 or X15.2. This includes staged and revision surgery where there may be significant periods of time between procedures, and where only a single procedure has been performed.](#)

#### **Examples:**

[Bilateral inframammary fold mastectomy and free nipple sharing grafts chest masculinisation \(female to male\)](#)

[X15.2 Combined operations for transformation from female to male](#)

[B27.4 Total mastectomy NEC](#)

[B36.3 Nipple sharing NEC](#)

[Z94.1 Bilateral operation](#)

[Gender affirming total abdominal hysterectomy and bilateral salpingo-oophorectomy \(female to male\)](#)

[X15.2 Combined operations for transformation from female to male](#)

[Q07.4 Total abdominal hysterectomy NEC](#)

[Q22.1 Bilateral salpingoophorectomy](#)

[Gender affirming bilateral insertion of subcutaneous tissue expanders into breast \(male to female\) first stage](#)

[X15.1 Combined operations for transformation from male to female](#)

[S48.2 Insertion of skin expander into subcutaneous tissue of breast](#)

[Y70.3 First stage of staged operations NOC](#)

[Z94.1 Bilateral operation](#)

[Gender affirming bilateral exchange of tissue expanders to permanent breast implants \(male to female\) second stage](#)

[X15.1 Combined operations for transformation from male to female](#)

[B30.4 Renewal of prosthesis for breast NEC](#)

[Y71.1 Subsequent stage of staged operations NOC](#)

[Z94.1 Bilateral operation](#)

~~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.~~

**PCSX6** has been retired as **X35.1 Intravenous induction of labour** has been retired from the classification.

~~PCSX7: Red Cell Survival procedure (X35.8)~~

~~Red Cell Survival procedure must be coded using:~~

~~**X35.8—Other specified other intravenous injection**~~

**PCSX7** has been retired due to the addition of a new index entry for the procedure in Section I of the Alphabetical Index. Note that a change in the OPCS-4 Editorial Principles means that index entries to **.8** and **.9** codes can be added where appropriate.

~~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.~~

**PCSX11** retired following addition of a note at **X45** in the OPCS-4.11 Tabular List

## PCSX35: Active cooling and rewarming therapy (X51)



X51.1 Rewarming therapy must only be assigned when the patient is treated for hypothermia, it must not be assigned where:

- treatment is given to prevent hypothermia
- rewarming has taken place following active cooling, as this is implicit in the assignment of X51.2 Active cooling
- only passive external rewarming has taken place.

X51.2 Active cooling must be coded each time it is carried out.

X51.2 must not be assigned in instances where cooling is focussed on a single body area, for example, the use of cooling caps in chemotherapy patients.

Passive external rewarming allows the patient's own body heat to rewarm them by providing a warm environment and insulating materials like blankets.

Active cooling involves a reduction of the entire body core temperature. It may also be described as 'therapeutic hypothermia' or 'therapeutic cooling' or as 'deep hypothermic arrest' (DHCA) or 'deep hypothermic arrest with cerebral perfusion' within a cardiac surgery operation note.

## 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.~~

PCSX15 retired following the addition of a new note at X50.5 in the OPCS-4 Tabular List.

## PCSX20: Radiotherapy (X57, X65, X67–X69)



### Preparation for radiotherapy

Preparation for radiotherapy is coded as follows:

- X57.- Preparation for other radiotherapy, 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**.~~

The following codes are radionuclide/radioisotope/molecular therapy and do not require the addition of a code from categories **Y35, Y36, Y89, Y91** or **O44**:

- **X65.5 Oral delivery of radiotherapy for thyroid ablation**
- **X65.7 Delivery of radionuclide therapy NEC**
- **X69.3 Oral delivery of radionuclide therapy NEC**
- **X69.4 Intravenous injection delivery of radionuclide therapy**
- **X69.5 Intravenous infusion delivery of radionuclide therapy**

**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 ([external beam](#), [brachytherapy](#)) for a series of identical treatments. This is similar to a medical prescription. Different anatomical sites treated concurrently [by external beam or brachytherapy](#) 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 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**

**Excludes: [Delivery of a fraction of stereotactic external beam radiotherapy \(X69.6\)](#)**

**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**

**Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)**

**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**

**X69.6 Delivery of a fraction of stereotactic external beam radiotherapy**

**Includes: Delivery of a fraction of stereotactic external beam ablative radiotherapy**

**Note: Use a subsidiary code to identify external beam radiotherapy (Y91)**

~~**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 stereotactic 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**

**Excludes: Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)**

**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**

**Excludes:** Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)

**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

**Excludes:** Delivery of a fraction of stereotactic external beam radiotherapy (X69.6)

**Note:** Use a subsidiary code to identify external beam radiotherapy (Y91)

**Y91.2** Megavoltage treatment for simple radiotherapy

**Z75.9** Bone of pelvis NEC

Preparation and delivery of Lutetium (Lu-177) radionuclide via intravenous infusion

**X57.1** Preparation for radionuclide therapy

**Includes:** Preparation for molecular radiotherapy

**X69.5** Intravenous infusion delivery of radionuclide therapy

**Includes:** Intravenous infusion delivery of molecular radiotherapy

**PCSX20** updated to incorporate new codes and amendments to existing codes in OPCS-4.11 affecting radiotherapy. New supplementary information definition has been developed and text agreed by the EWG Principal Physicist from British Nuclear Medicine Society and specialist Physicist in dosimetry from Institute for Cancer Research.

## **PCSX26: Reamputation (X12.1)**

### **Examples:**

*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 of foot through metatarsal bones

**Z94.3** Left sided operation

## PCSX27: Delivery of chemotherapy for neoplasm (X72-X73)

### Examples:

A breast cancer patient is prescribed FEC-T, this consists of the patient receiving 3 concurrent cycles of FEC 100, once these are 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**

Day 1, Cycle 1, 2, 3 Docetaxel 100mg

**X72.3 Delivery of simple parenteral chemotherapy for neoplasm at first attendance**

Example at **PCSX27** updated as the word 'concurrent' used in relation to FEC 100 was causing confusion. Docetaxel is given after FEC 100 cycles are finished but the layout of the example wording implied they are given on the same day.



## CHAPTER Y SUBSIDIARY CLASSIFICATION OF METHODS OF OPERATION (Y01–Y99, O44, O48)

### Chapter standards and guidance

## PChSY1: Use of codes in Chapter Y

### Examples:

*Laser therapeutic keratectomy right eye*

**C45.1 Superficial keratectomy**

*Includes: Laser keratectomy*

**Note: For laser keratectomy and phototherapeutic 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** [Percutaneous endoscopic total excision of meniscus of knee joint](#)~~Endoscopic total excision of meniscus of knee joint~~
- Y08.1** Laser excision of organ NOC
- Z94.2** Right 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)**~~

Guidance box removed as instructions on the use of codes in **Y79** has been added to **PCSY6** and **PCSY7**.

## Coding standards and guidance

### ~~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.~~

**PCSY5** has been retired and replaced with **PGCS23**

### **PCSY6: Approach to organ (Y45–Y52, ~~and~~ Y74–Y77, [Y79](#) and [Y85](#))**



Where a method of approach classifiable to categories **Y45–Y52, ~~and~~ Y74–Y77, [Y79](#) and [Y85](#)** is not incorporated within the body system code description, a code from [these](#) 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.~~ [This does not apply to \*\*Y48.- Approach to spine through back, Y49.3 Thoracotomy approach NEC\*\* and \*\*Y50.2 Laparotomy approach NEC\*\* \(except when coding the removal of vaginal or transobturator tape using codes in categories \*\*M53\*\* and \*\*M57\*\* as per \*\*PCSM11: Removal of vaginal and transobturator tape \(M53 and M57\)\*\*\), as \[these codes are not required for open spinal, thoracic or abdominal surgery when the laminectomy/incisions are the only means of approach in order to access the procedure site. See also \\*\\*PGCS8: Incision as a means of approach.\\*\\*\]\(#\)](#)

Where a number of procedures have taken place using [the same or](#) different methods of approach a code from categories (~~Y45–Y52, and Y74–Y77, Y79 and Y85~~) must be assigned [directly](#) after each body system code.

[When a code from one of the following categories is used to supplement a body system code, the approach code from categories Y45–Y52, Y74–Y77, Y79 and Y85 must be assigned directly after the supplementary code:](#)

- [L76.- Endovascular placement of stent](#)
- [L89.- Other endovascular placement of stent](#)
- [O20.- Endovascular placement of stent graft](#)
- [V55.- Levels of spine](#)

### [Procedures performed by percutaneous endoscopic approach](#)

[Codes that state ‘percutaneous endoscopic’ in the code description do not require an approach code from Y74–Y76, unless the approach code provides additional detail about the type of approach, e.g., Y75.3 Robotic assisted laparoscopic approach to abdominal cavity.](#)

#### See also:

- [PGCS1: Endoscopic and \*\*percutaneous endoscopic procedures\*\*minimal \*\*access operations\*\* that do not have a specific code](#)
- [PGCS8: \*\*Incision as a means of approach\*\*](#)
- [PChSK1: Percutaneous transluminal operations that do not have a specific code](#)
- [PCSY16: \*\*Minimally invasive approach \(Y77.3\)\*\*](#)

~~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.**~~

~~[For open spinal, thoracic, and abdominal surgery, the laminectomy/incision for access is considered an inherent component of the procedure. Coding these methods of access separately would create redundant data, inflate perceived procedural complexity, and not accurately reflect distinct clinical interventions or resource consumption.](#)~~

[In contrast, approaches to the brain \(Y46 \*\*Open approach to contents of cranium\*\* and Y47 \*\*Burr hole approach to contents of cranium\*\*\) represent significantly more complex and resource-intensive procedures in their own right. These involve intricate anatomical considerations, specialised equipment and prolonged theatre time, and carry unique risks and potential complications distinct from the subsequent intracranial procedure.](#)

There is no sequencing instruction when assigning multiple codes from Y45–Y52, Y74–Y77, Y79 and Y85.

**Examples:**

*Open biopsy of lesion of frontal region of brain through frontal burrhole*

A08.1 Biopsy of lesion of tissue of frontal lobe of brain NEC

~~A04.1 Open biopsy of lesion of tissue of frontal lobe of brain~~

**Y47.2 Frontal burrhole approach to contents of cranium**

*FESS repair of sphenoid sinus*

**E15.3 Repair of sphenoidal sinus**

Y85.1 Functional endoscopic sinus surgery

~~Y76.1 Functional endoscopic sinus surgery~~

*Laparotomy with excision of cyst of left ovary*

Q43.2 Excision of lesion of ovary

Z94.3 Left sided operation

*Laparoscopic total abdominal hysterectomy and bilateral salpingoophorectomy*

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

*Hysteroscopic microwave endometrial ablation*

Q17.6 Endoscopic microwave ablation of endometrium

*Arthroscopic adhesiolysis of left temporomandibular joint*

V64.3 Percutaneous endoscopic release of temporomandibular joint

Z94.3 Left sided operation

*Laparoscopic-assisted percutaneous endoscopic gastrostomy (LAPEG)*

G44.5 Fibreoptic endoscopic percutaneous insertion of gastrostomy

## [Y75.1 Laparoscopically assisted approach to abdominal cavity](#)

[Laparoscopic-assisted laser excision of ovarian cyst](#)

## [Q49.1 Percutaneous endoscopic extirpation of lesion of ovary NEC](#)

### [Y75.1 Laparoscopically assisted approach to abdominal cavity](#)

### [Y08.2 Laser excision of lesion of organ NOC](#)

**PCSY6** has been updated to add an exception to cover incisions as a means of approach and instruction on how to code combined approaches that may use incisions as one of the methods. New content has been added to instruct sequencing rules with specific body system codes, e.g. **L76**, **V55** and the assignment of approach codes in addition to 'percutaneous endoscopic' procedures. New examples have been added to support the new instructions.

## [PCSY17: Robotic approach to organ and body cavity \(Y45.2, Y74.3, Y75.3, Y76.5 and Y85.5\)](#)

[When a procedure has been performed using robotic assistance, code assignment is dependent on the method of approach.](#)

### [Percutaneous endoscopic approach](#)

[Assign one of the following codes when the robotic system utilises an endoscope and the procedure is performed endoscopically via minimal incisions. Code assignment is based on the approach e.g., thoracoscopic, laparoscopic, arthroscopic](#)

- [Y74.3 Robotic assisted thoracoscopic approach to thoracic cavity](#)
- [Y75.3 Robotic assisted laparoscopic approach to abdominal cavity](#)
- [Y76.5 Robotic assisted percutaneous endoscopic approach to other body cavity](#)

### [Endoscopic approach](#)

[Assign Y85.5 Robotic assisted endoscopic approach to organ when the robotic system utilises an endoscope and the procedure is performed endoscopically via a natural orifice, e.g. via the urethra or mouth](#)

### [Non-endoscopic approach](#)

[Assign Y45.2 Robotic assisted approach to organ NEC when the surgeon has direct visualisation of the surgical site and the robotic system does not utilise an endoscope.](#)

Where there is doubt as to whether the robot utilises an endoscope, clarification must be sought from the responsible consultant.

Many robotic assisted procedures involve a surgeon sitting at a remote console and viewing the surgical site through an endoscopic camera. The endoscope sends a high definition, magnified 3D view of the surgical site to a console where the surgeon is seated. The surgeon controls the robotic arms from the console with their hand movements. An example of this type of robot is the da Vinci Surgical System; widely used in laparoscopic and cardiothoracic surgery, as well as transoral surgery to treat hard to reach areas like the back of the throat, tonsils, or base of the tongue.

Robotic assisted procedures that do not utilise an endoscope typically involve the surgeon standing at the operating table, directly viewing the patient, and controlling robotic arms to guide their surgical instruments based on a pre-operative 3D plan. These types of robotics tend to be used in orthopaedic, spinal and neurosurgery. An example of this type of robot is the Mako SmartRobotics, primarily used for hip and knee replacements.

### **Examples:**

Robotic-assisted laparoscopic kidney transplant from live donor

**M01.2 Allotransplantation of kidney from live donor**

**Y75.3 Robotic assisted laparoscopic approach to abdominal cavity**

Transurethral water-jet ablation of prostate using robotic handpiece with integrated cystoscopy. A transrectal ultrasound (TRUS) probe was inserted into the rectum to provide real-time high-resolution imaging of the prostate.

**M65.7 Endoscopic ablation of prostate using waterjet**

**Y85.5 Robotic assisted endoscopic approach to organ**

**Y53.2 Approach to organ under ultrasonic control**

Robotic-assisted primary total hip replacement using cement

**W37.1 Primary total prosthetic replacement of hip joint using cement**

**Y45.2 Robotic assisted approach to organ NEC**

### **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**.~~

~~Where the type of image control classifiable to categories **Y53, Y68 and Y78** is not incorporated within the body system code description, a code from these categories must be assigned directly after the code(s) for the procedure (i.e. body system code(s) plus any subsidiary Y codes including other approach codes in **Y45–Y52, and Y74–Y77, Y79 and Y85** used to enhance the body system code, see also **PCSY6: Approach to organ (Y45–Y52, Y74–Y77, Y79 and Y85)**). The exception to this is **PCSY11: Gestational age (Y95)**.~~

~~When a code from one of the following categories is used to supplement a body system code, the type of image control must be sequenced after the supplementary code:~~

- ~~**L76.- Endovascular placement of stent**~~
- ~~**L89.- Other endovascular placement of stent**~~

- [O20.- Endovascular placement of stent graft](#)
- [V55.- Levels of spine](#)

[Where the type of image control has not been documented and the body system code description does not state image control, \*\*Y53.9 Unspecified approach to organ under image control\*\* or \*\*Y78.9 Unspecified arteriotomy approach to organ under image control\*\* must be assigned directly after the codes for the procedure.](#)

[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, unless instructional notes provide an exception.](#)

[Codes that state the type of image control in the code description, for example \*\*L72.6 Intravascular ultrasound of artery NEC\*\*, do not require a code from \*\*Y53 Approach to organ under image control\*\* or \*\*Y68 Other approach to organ under image control\*\* unless the code provides additional detail about the type of image control, for example, \*\*Y68.1 Approach to organ under contrast enhanced ultrasonic control\*\*.](#)

[A code to classify the image control must not be assigned where image control has been used to:](#)

- [check the anatomical position of an organ/fracture site before, during or after a procedure](#)
- [check the position of a prosthesis/fixator after insertion](#)
- [confirm a procedure is complete](#)

[Codes within category \*\*Y78 Arteriotomy approach to organ under image control\*\* must only be assigned when 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](#)
- [cutting of artery](#)

[The arteriotomy will always require closure with either suture or clips to the overlying skin and a code to classify the method of closure must not be assigned in addition.](#)

**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:

#### [Balloon dilatation of oesophagus using fluoroscopic guidance](#)

[G21.4 Intubation of oesophagus NEC](#)

[Y40.3 Balloon dilation of organ NOC](#)

[Y53.4 Approach to organ under fluoroscopic control](#)

#### [Stereotactic laser ablation of thalamic lesion using frontal burrhole approach and navigation-guidance](#)

[A03.2 Stereotactic ablation of tissue of thalamus](#)

[Y46.2 Frontal open approach to contents of cranium](#)

[Y08.4 Laser destruction of lesion of organ NOC](#)

[Y68.5 Approach to organ under navigation guided control](#)

#### ~~*[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~~

**PCSY7** has been rewritten and reformatted to reduce ambiguity. The instructions within the standard have not changed. Some examples have been removed where they are duplicating the same key learning point.

**PCSY14: Electrochemotherapy/~~electroporation~~ (Y12.3)**

Where electrochemotherapy ~~or electroporation~~ is performed following delivery of a chemotherapy regimen this must be coded as follows:

~~Body~~ [Destruction body](#) system chapter code

**Y12.3 Electrochemotherapy to lesion of organ NOC**

*Includes: Electroporation to lesion of organ [with chemotherapy](#) NOC*

Chapter Z site code(s), [where this adds further information](#)

**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~~

[S11.8 Other specified other destruction of lesion of skin of other site](#)

**Y12.3 Electrochemotherapy to lesion of organ NOC**

**Z49.6 Skin of shoulder**

**Z94.3 Left sided operation**

**PCSY14** updated removing all reference to electroporation following the authoring of a new codes at **Y10.6** and **Y17.7**. Example updated to reflect that electrochemotherapy is a destructive treatment.

### In vitro fertilisation (Y96)

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

**PCSQ3** retired following the amendment of the notes at **Q13.1**, **Q21.1** and **Q38.3** instructing the addition of codes from **Y96** demonstrating the type of fertilisation used.

### PCSY3: Lipofilling (Y39.4)

#### Example:

Lipofilling of both cheeks. Subcutaneous ~~F~~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*~~

**Y69.8 Other specified harvest of other tissue**

**Z50.4 Skin of leg NEC**

*Includes: Subcutaneous tissue of other site*

**Z94.2 Right sided operation**

**PCSY3** updated due to an error noted in the codes assigned for fat harvest without skin.

### PCSY16: Minimally invasive approach (Y77.3)

**Y77.3 Minimally invasive approach to organ** must only be used for procedures performed through minimal incisions that do not utilise a microscopic or robotic approach (Y45), or an endoscopic or percutaneous endoscopic approach (Y85 or Y74-Y76).

Any uncertainty as to whether a procedure has been performed using a minimally invasive incision must be clarified with the responsible consultant in order to ensure correct code assignment.

#### See:

- **PChSC1: Minimally invasive glaucoma surgery (MIGS)**
- **PCSY6: Approach to organ (Y45–Y52, Y74-Y77, Y79 and Y85)**
- **PCSY7: Approach to organ under image control (Y53, Y68 and Y78)**

In OPCS-4, minimally invasive refers to a technique that utilises smaller incisions to insert specialised instruments and visualisation tools to minimise disruption to surrounding tissues. This term is often used in joint replacement and glaucoma surgery.

### **Examples:**

Minimally invasive video-assisted partial thyroidectomy (responsible consultant confirms that a small incision was made above the sternal notch and an endoscope was inserted through the incision and partial excision of the thyroid lobe was carried out)

**B08.6 Partial thyroidectomy NEC**

**Y85.8 Other specified endoscopic approach to organ**

Minimally invasive surgical fusion of the sacroiliac (SI) joint under fluoroscopic guidance (responsible consultant confirms that the SI joint was accessed laterally through a small incision made in the buttock to reach the ilium)

**W62.1 Primary arthrodesis and internal fixation of joint NEC**

**Y77.3 Minimally invasive approach to organ**

*Note: Use a subsidiary code to identify method of image control (Y53)*

**Y53.4 Approach to organ under fluoroscopic control**

**Z84.1 Sacroiliac joint**

Transanal Minimally Invasive Surgery (TAMIS) with excision of rectal adenoma (responsible consultant confirms an endoscope was inserted via a port placed in the anus. The rectal lesion was identified and excised using endoscopic instruments)

**H41.2 Peranal excision of lesion of rectum**

**Y85.8 Other specified endoscopic approach to organ**



## **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)

### **Coding standards and guidance**

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

### **Examples:**

Laparoscopic ~~Endoscopic~~ cryoablation of lesion of right kidney, patient previously had their left kidney removed 3 years ago.

M10.4 Percutaneous endoscopic cryoablation of lesion of kidney

~~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 Percutaneous endoscopic decompression of joint

~~W84.4 Endoscopic decompression of joint~~

**Z81.2 Acromioclavicular joint**

**Z94.2 Right sided operation**

