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Proposal for the generation of specific codes for National QA
Programme in Histopathology – Version 3.0

Developed by

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1. Introduction

A key aspect of the National QA programme in Histopathology is the collation and review of data at a local and national level. To ensure the accuracy and consistency of data reported it is recommended to standardise the coding of medical terms across all histopathology laboratories. The current variability in the version and use of the coding system across all histopathology laboratories limits the degree of standardisation attainable. Full standardisation will require significant investment and implementation time which is not expected within the timeframe of implementation of this programme.

Therefore, this document recommends a set of QA Programme specific codes to capture the data as recommended in the guidelines. This document also proposes a minimal set of standard Procedure codes to ensure meaningful reporting of TAT.

It is accepted that some laboratories, due to local practice, may utilise alternative codes or systems to collate some or all of the data.

2. Recommended Procedural Codes

It is recommended to adopt the following list of P codes for coding QA Programme required data. It is anticipated that as the QA Programme evolves these categories as outlined in the table below may require further refinement.

QA Guideline	Code	Expansion
1.1	P01	Small Biopsy
	P02	GI Endoscopic Biopsy
	P03	Non Biopsy – Cancer Resection
	P04	Non Biopsy – Other
	P06	Non Gynaecological cytology – FNA
	P07	Non Gynaecological cytology – Exfoliative
	P09	Gynaecological cytology

Note: The following is a guide as to what should be included as part of the newly proposed categories.

- Small biopsy – Includes Core, Needle, Punch, Shave, Curetting
- Non biopsy other – All other surgical specimens which are neither small biopsies nor cancer resections

3. Recommended QA codes

It is recommended to adopt the following list of Q codes for coding QA Programme required data.

QA Guideline	Code	Expansion
1.2.1	Q001	Case referred externally for review
	Q002	Case received internally for review
	Q003	Case referred externally for opinion
	Q004	Inter Institutional Agreement
	Q005	Inter Institutional Disagreement
1.2.2	Q006	Case subject to Intradepartmental Consultation
1.2.3	Q007	Frozen section correlation - Concordance
	Q008	Frozen section correlation - Deferral
	Q009	Frozen section correlation - Major discordance
1.2.4	Q010	Cytology/histology correlation – Concordance
	Q011	Cytology/histology correlation - Discordance - False positive
	Q012	Cytology/histology correlation - Discordance - False negative
1.2.5	Q013	Case subject to focused real time review
	Q014	Case subject to report completeness review
	Q015	Focused review - Agreement
	Q016	Focused review - Disagreement
	Q030	Report Complete
	Q031	Report Incomplete
1.2.6	Q017	Case subject to MDT review
	Q018	MDT review - Agreement
	Q019	MDT review - Disagreement
1.2.10	Q020	Supplementary Reports
	Q021	Amended Reports
	Q022	Corrected Reports
1.2.11	Q023	Report Communicated Directly to clinician

Note:

- A unique code has not been provided in the above standard set for Cytology/Histology Interpretation errors or Cytology/Histology Sampling errors. If an individual laboratory requires use for such codes the following are recommended.

QA Guideline	Code	Expansion
1.2.4	Q024	Cytology Interpretation error
	Q025	Histology Interpretation error
	Q026	Cytology sampling error
	Q027	Histology sampling error

- It is considered necessary to provide unique codes for agreement & disagreement for QA Guideline 1.2.1, 1.2.5 and 1.2.6. If a case is subject to more than one form of review (e.g. Focused review and InterInstitutional review) coding as above is recommended to facilitate easy retrieval of the associated agreement or disagreement for each review type. However, if an individual laboratory requires use for general codes the following are recommended.

QA Guideline	Code	Expansion
1.2.4	Q028	Agreement
	Q029	Disagreement

4. Revision History

<i>Version</i>	<i>Date</i>	<i>Changes</i>	<i>Details</i>
1.0	26/08/09	None	Original baseline version of Proposal
2.0	03/12/09	Procedural Codes P04 & P05	Categories 'Non Biopsy – Excision / Resection other' and 'Non Biopsy – Remainder' combined into category 'Non Biopsy Other' and coded as P04. P05 code is no longer assigned to any group.
3.0	07/05/10	QA Codes	New codes recommended for the collection of Report Completeness data.