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Proposal for the generation of specific codes for National QA Programme in Histopathology – Version 5.0

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. All local codes relating to the QA programme will be mapped to a set of national codes in the NQAIS reporting system.

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
	P10	Post mortem - Coroner
	P11	Postmortem - Non Coroner/Consented/House

See appendix 1 for further guidance on what should be included in the above categories.

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
	Q032	Case subject to random review
	Q033	Random review - Agreement
	Q034	Random review - Disagreement
	Q030	Report Complete
	Q031	Report Incomplete
1.2.6	Q017	Case subject to MDT/M&M review
	Q018	MDT/M&M review - Agreement
	Q019	MDT/M&M review - Disagreement
1.2.10	Q020	Supplementary Reports
	Q021	Amended Reports
	Q022	Corrected Reports
1.2.11	Q023	Report Communicated Directly to clinician
1.3.2 & 1.3.3	Q035	Post mortem – Toxicology performed
	Q036	Post mortem – Histology performed
	Q037	Post mortem – Neuropathology performed
	Q038	Post mortem – Neither Toxicology nor Histology nor Neuropathology performed
	Q039	Postmortem – Organ retained
1.4.2	Q040	Perinatal & Paediatric Postmortem – SIDS/Metabolic
	Q041	Perinatal & Paediatric Postmortem – Non SIDS/Metabolic
	Q042	Autopsy case review satisfactory
	Q043	Autopsy case review unsatisfactory
	Q044	Perinatal & Paediatric autopsy satisfactory ≥ Min Accepted Score
	Q045	Perinatal & Paediatric autopsy unsatisfactory < Min Accepted Score
1.2.7	Q052	Pre analytic high risk non conformance
	Q053	Pre analytic medium risk non conformance
	Q054	Pre analytic low risk non conformance
	Q055	Analytic high risk non conformance

QA Guideline	Code	Expansion
	Q056	Analytic medium risk non conformance
	Q057	Analytic low risk non conformance
	Q058	Post analytic high risk non conformance
	Q059	Post analytic medium risk non conformance
	Q060	Post analytic low risk non conformance
1.2.3	Q061	Frozen section turnaround time ≤ 20mins
	Q062	Frozen section turnaround time > 20mins

Notes:

- 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

- For recording results of overall autopsy evaluation at Adult Autopsy case review it is recommended that results of excellent, good and satisfactory be coded as Q042 ‘Autopsy case review satisfactory’ and results of poor and unacceptable be coded as Q043 ‘Autopsy case review unsatisfactory’. If an individual laboratory wishes to record each evaluation result individually for results of excellent, good, satisfactory, unacceptable and poor, the following codes are recommended:

QA Guideline	Code	Expansion
1.3.2	Q046	Excellent
	Q047	Good
	Q048	Satisfactory
	Q049	Unacceptable
	Q050	Poor

- For recording results of autopsy evaluation at Perinatal & Paediatric Autopsy case review it is recommended that cases with scores equal to or above the minimum accepted score(MAS) for a given autopsy type (i.e. SIDS or SB & NND) be coded as ‘satisfactory’ and cases with scores below the MAS for a given autopsy type be coded as unsatisfactory. Given that some PMs are limited to a specific region of the body or a specific test, it should be noted that only complete PMs can be scored

using the scoring system provided in the 'Guidelines for the Implementation of a National Quality Assurance Programme in Histopathology'.

3. Appendix 1

3.1. Guidance on procedural code categories:

Code	Clarification
P01	Core, needle, punch, shave and curetting biopsies including liver, bronchial, lung core, endometrial pipelle, skin punch, prostate, renal, lymph node core and targeted bone core biopsy for tumour
P02	Endoscopic GI biopsies from oesophagus to anus
P03	Cancer resections include: • specimens with no residual primary tumour (mastectomy, colectomy for malignant polyp, etc). • regional node dissections without primary resection (axillary, neck dissections) • wide local excision for melanoma with or without sentinel node biopsy & • hysterectomy for hyperplasia as well as invasive tumour. Orchidectomy for neoplasm • Salivary gland / thyroid resections for neoplasm Note: For Staging operative procedures prior to resection, specimens received can vary and coding depends on their nature(e.g. Lymph node biopsies, liver biopsies) Coding depends on nature of the specimen i.e. Liver biopsy = P01, lymph node excisional biopsy = P04 If the definitive cancer resection subsequently is performed the specimen is coded P03
P04	All other surgical specimens which are neither small biopsies nor cancer resections including TUR Bladder ,TURP, lymph node biopsy, bone marrow biopsy, colectomy for diverticular disease, skin ellipse / shave excisions, hysterectomy for fibroids, endometrial currettings, Lymph nodes for lymphoma diagnosis, appendix, gallbladder, fallopian tubes, placenta, TAH for non malignancy, Colon resections for non malignancy

3.2. Frequently asked questions on procedural code categories

1. Q: Are skin lesions P01 - small biopsy or P04 - non biopsy other?
   A: P01 - small biopsy

2. Q: How do you code skin melanoma punch biopsies?
   A: P01 – small biopsy

3. Q: How do you code an excision of melanoma?
   A: P03

4. Q: How do you code carcinoma biopsies?
   A: Coding of carcinoma biopsies is dependent on the site of the biopsy.
   GI = P02, Non GI = P01

5. Q: Can you confirm that the P code relates to the case number and not the specimen number. If so, if there is a small biopsy as specimen A and a resection as specimen B is the whole case coded as P03?
   A: P code relates to case number. The whole case is coded as P03

6. Q: Can a case have more than one P code?
   A: No. P code is used to highlight complexity for TAT and workload. If more than one procedure was applied to a case choose the P code which most accurately represents the complexity involved

7. Q: Are endometrial currettings P01 or P04?
   A: P04. Pipelle endometrial biopsies are P01

8. Q: Does P02 include respiratory biopsies?
   A: No

4. Revision History

Version	*Date*	*Changes*	*Details*
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.
4.0	29/07/10	Procedural Codes & QA Codes	New codes recommended for the collection of Adult & Perinatal & Paediatric Autopsy QA data
5.0	28/06/11	QA Codes	New codes added for the collection of lab based non conformances & frozen section TAT and further guidance included on procedural code classification in appendix 1