Outpatient activity coding in Oral Surgery

Information for secondary care trusts

GIRFT Clinical coding team

Oral surgery GIRFT Coding working group

Version 2.0: For use with national OPCS-4.10 procedure codes (introduced April 2023)

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Foreword by Professor Judith Jones, Chair of the Oral Surgery GIRFT coding working group.

In September 2021, the Getting It Right First Time (GIRFT) Programme National Specialty Report into Hospital Dentistry was published. The work had been led by Liz Jones, who had visited 106 hospital dental services in England, meeting with clinical leads and management, to look at clinical activity and patient safety. Never before had such an in-depth review of hospital dental services been undertaken and the aim was to improve the quality of care within the NHS by reducing unwarranted variations.

The GIRFT process is not simply to tell us whether we are 'getting it right' but to identify areas where we can improve services towards the goal of getting it right first time, every time.

The report highlighted variation within all dental specialties including Oral Surgery which meant that what was being recorded was not comparable between and within different departments and NHS Trusts, leading to a lack of meaningful information on clinical activity. I was approached by Liz as a member of BAOS and ABAOMS and tasked with putting together a group of oral surgery clinicians to look at the codes that are commonly used in OS. We were extremely fortunate to work with the GIRFT coding team and we also liaised with BAOMS members for further input.

Our work was not to change any of the procedure codes or their descriptions, but we needed to work out an interpretation to guide clinicians as to when each code should be used. We hope that we have accomplished this but welcome and value your comments on this guidance on coding. Feedback can be provided to BAOS or the GIRFT clinical coding team using email england.girft.coding@nhs.net. We hope you find this guide useful and that it stimulates discussion on capturing accurate data and auditing activity, as well as providing evidence to use in discussions with trusts and commissioners.

I am extremely grateful to all members of the working group for their time, energy, expertise and contributions to complete this piece of work and to Liz for her sheer enthusiasm and passion to push this forward. I am also immensely grateful to the GIRFT coding team for their patience and willingness to share their considerable knowledge on coding with us.

Professor Judith Jones, Chair, Oral surgery GIRFT Coding working group. BDS Programme Director/ Honorary Consultant in Oral Surgery, KCL/ Guys & St Thomas' NHS Foundation Trust

Oral Surgery outpatient procedure coding

What is this document for?

This document is for oral surgeons and others who are involved with capturing OPCS-4 procedure codes for oral surgery procedures in the outpatient setting. This document explains how to use the included tables of standardised and recommended OPCS-4 procedure codes. The procedure codes are consistent with the inpatient national clinical coding standards and will enable meaningful comparison of activity across care delivery settings (outpatient, daycase, inpatient).

Additional information on other data items which are important for outpatient activity is included in the Appendix.

Why is outpatient procedure coding important?

Accurate coded data for all surgical interventions is essential for a range of reasons:

- Used for care quality metrics
- Service design and visibility of activity
- Understanding rates of specialised care
- Income and commissioning

All procedures should be coded in the same way, independently of setting. The procedure codes in this document are consistent with the national code definitions and are the same as the codes used for daycase procedures. The procedure codes in the tables below are the most up to date version (version 10, known as OPCS-4.10) and correct for use from 1st April 2023. Diagnosis coding for outpatients is important also but is beyond the scope of this document.

It is important that all consultants and their teams follow this guidance and use the codes as suggested in this booklet. We can then drive the changes required and ensure ongoing improvement in the quality of oral surgery care we provide.

What do you need to do?

Ensure that all outpatient procedures are coded consistently using OPCS-4 codes.

Oral surgeons are asked to ensure that the procedures that they carry out in the outpatient setting are captured in the clinical record and coded using the OPCS-4 codes recommended here.

Whatever system is used at your trust for coding outpatient procedures can be continued. Where there are existing code lists and procedure tables, please ensure that the coding is aligned with the recommended codes.

In trusts there will be systems in place for capturing clinical codes for outpatient procedures. However, the national outpatient dataset shows widespread variation in the accuracy and quality of the procedure codes used by hospitals for outpatient attendances.

Implementation

Who in the hospital needs to be involved in implementing outpatient procedure coding? This depends on what systems are in place and who has responsibility for systems, processes and data entry in outpatients. The roles which may be involved include:

- Clinical team
- Operations managers
- Outpatients managers and administration team
- Clinical coding team
- Technology/IT team
- Information and finance

We have presented standardised tables of procedure codes that are associated with the common procedures described in the tables. Whatever method of capturing clinical codes is in place at your trust should continue, with the code lists (e.g. tick lists printed on clinic outcome forms or drop down menus on electronic systems) updated to match the recommended OPCS-4 codes.

Clinical teams should use the tables to create a customised pick list of procedure codes for all procedures that they carry out in their clinics.

The purpose of the list is to make it easy for surgeons to note what has occurred during an outpatient attendance so that the correct OPCS-4 codes can be recorded and reported in clinical data.

Customisation of lists

Oral surgeons should tailor the procedure code list to suit their needs. Only the procedures carried out in a particular setting need to be included as options. Lists can be produced for specific clinics if necessary and these shortened lists will be easier to use.

Using the code tables provided in this document, compile a list of the procedure codes which are relevant for your setting.

Please do not change the codes assigned for specific procedure terms – consistency in the codes is the point of this document and tables.

What should the lists look like?

The essential lists of procedure descriptions and associated codes are described in the tables below.

The clinical terms and codes can be presented to users in whatever order is useful. Options for sorting the lists include:

- Most common procedures first
- Sites and subheadings grouped together
- Diagnostic and therapeutic groups
- Alphabetically, anatomically or otherwise

Using the structure described in the code tables is recommended but not essential.

Multiple procedure codes

Oral surgeons need to ensure that they have recorded all the relevant procedures for an attendance using the codes described in this document. Procedures should be coded whenever they take place, for both first and follow up appointments.

More than one OPCS-4 code can be recorded per activity/visit. However, when it is implicit that undertaking one procedure will always involve another procedure, the additional procedure would not require coding. For example, periodontal surgery will almost always require placement of sutures, but the suture procedure would not require coding.

Procedure descriptions and OPCS-4 code definitions

For the sake of space and clarity the procedure descriptions used in the coding tables below are not the same as the national standard definitions for the OPCS-4 codes. However, we have taken great care to make sure that the OPCS-4 codes used for each procedure description are the most accurate possible. The codes recommended for each procedure description adhere to all relevant national coding standards and meet the code definitions. The descriptions in the Inclusions and Exclusions columns provide additional information on what activity each of the OPCS-4 codes should be used for.

Colleagues can access the national standard OPCS-4 procedure code descriptions by looking on the GIRFT academy website (hospital dentistry), by asking their local clinical coding team or by contacting the Terminology and Classifications Delivery Service (TCDS) via support.digitalservices@nhs.net

For Oral Surgery, we have confirmed definitions for the codes defined in the OPCS-4 manual and are here issuing guidance on how to ‘ideally’ code for the procedures we undertake in our services. The guidance is not all encompassing, but we hope covers the main procedures happening across the secondary care service. There are a few clinical procedures that we still cannot code accurately with the OPCS-4.10 codes and we will continue to participate in the long term OPCS-4 revision process.

We acknowledge that changes to coding procedures could have an impact on tariff setting and, potentially, income related to the activity. Providers and commissioners should discuss the impact of any

changes and agree an appropriate local solution. The solution should not delay the implementation of the standardised OPCS-4 procedure codes.

Outpatient and daycase procedure coding differences

This guidance document focuses on outpatient procedure codes. In most cases, trained clinical coders are not directly involved in code assignment for outpatients. The code tables are designed for use by clinicians and do not require a trained coder to be involved.

Ideally, there should be no difference in how procedures are coded between outpatients and daycase facilities. The code tables in this guidance are consistent with inpatient/daycase procedure coding.

The main procedure code should be the same across all settings (outpatients and daycase). There are a couple of practical considerations which may lead to minor differences:

1. Procedure codes assigned for daycases are likely to be assigned by the clinical coding team. Clinical coders assigning procedure codes from the full clinical record may be able to record slightly more detail using additional codes, in some circumstances. An example of this would be graft augmentations of an alveolar ridge. The codes presented here (for alveolar ridge augmentation) are simplified for ease of use. Clinical coders could use some additional codes to record types of graft material used and the sites of harvest.
2. Clinical coders may not be able to obtain all the relevant clinical details from the records available to them. This may lead to variation in code assignment compared with clinicians selecting codes in outpatients based on a very clear understanding of the procedure just carried out.

Treatment function codes (TFC)

The Treatment Function Code (TFC) for **Oral Surgery is 140**; there are other TFCs for our allied dental and medical specialties. The TFC is set up at the clinic level and will be the same for all patients in a particular clinic.

It is important that TFC is correctly recorded for all oral surgery activity. TFC describes the function provided during the healthcare and is not the same as Main Specialty Code (which is defined by the main specialty of the responsible consultant - in our case Oral Surgery, but the code for OMFS is often used instead).

References in the NHS data dictionary: www.datadictionary.nhs.uk
Main Specialty and Treatment Function Codes Table (datadictionary.nhs.uk)

Oral surgeons should ensure that all of their outpatient activity is recorded with the correct Treatment Function Code (Oral Surgery TFC = 140).

Clinic types

There are a number of data items captured to differentiate clinic types. More information is included in the Appendix on the following clinic types:

- Single professional, multi-professional or multi-disciplinary
- Consultant led and nurse led clinics
- First and follow-up appointments
- Clinic names

Oral Surgery outpatient procedure code tables

This section contains fifteen code tables which together cover all of the procedure codes needed for outpatient procedures in Oral Surgery.

1. Dental extractions and management of complications related to extractions

Procedure descriptions and OPCS-4 codes for dental extractions and associated procedures in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F09.1	Surgical removal of impacted wisdom tooth	Removal of an unerupted or partially erupted wisdom tooth by raising a flap and/or removing bone and/or sectioning the tooth with a handpiece/osteotome	
F09.2	Surgical removal of impacted tooth	Removal of an unerupted or partially erupted tooth by raising a flap and/or removing bone and/or sectioning the tooth with a handpiece/osteotome	Impacted wisdom tooth (F09.1)
F09.3	Surgical removal of wisdom tooth	Removal of an erupted wisdom tooth by raising a flap and/or removing bone and/or sectioning the tooth with a handpiece/osteotome	
F09.4	Surgical removal of tooth	Removal of an erupted tooth by raising a flap and/or removing bone and/or sectioning the tooth with a handpiece	Wisdom tooth (F09.3) Impacted tooth (F09.2)
F09.5	Surgical removal of retained root of tooth	Removal of a root or roots by raising a flap and/or removing bone and/or sectioning the roots with a handpiece, retained root following coronectomy Note: for wisdom tooth add site Z25.2	
F09.6	Coronectomy	Removal of the crown of a tooth or crown plus coronal aspect of roots surgically	Coronectomy followed by root removal of same tooth during same procedure (F09.-)
F09.8		Do not use	
F09.9		Do not use	
F10.1	Full dental clearance	Removal of all remaining teeth (including wisdom teeth) in maxilla and mandible - irrespective of methodology - i.e. surgical or forceps/elevation	
F10.2	Upper dental clearance	Removal of all remaining teeth (including wisdom teeth) in maxilla - irrespective of methodology - i.e. surgical or forceps/elevation	
F10.3	Lower dental clearance	Removal of all remaining teeth (including wisdom teeth) in mandible - irrespective of methodology - i.e. surgical or forceps/elevation	

OPCS code	Procedure description	Inclusions and notes	Exclusions
F10.4	Extraction of multiple teeth	Forceps/elevation/luxation (non-surgical extraction) of multiple teeth	Surgical removal (F09.-) and removal of wisdom teeth
F10.5	Extraction of retained root of tooth	Forceps/elevation/luxation (non-surgical extraction) of a single root	
F10.8		Do not use	
F10.9	Simple extraction of single tooth	Forceps/elevation/luxation (non-surgical extraction) of a single tooth	Surgical removal tooth (F09.-) Wisdom tooth removal (F09.-)
F16.2	Management of persistent post-extraction bleeding	With suture placement	
F16.2 + Y32.3	Management of persistent post-extraction bleeding - with haemostatic material	Packing of post-extraction socket for persistent bleeding	
F16.3	Management of a dry socket	Dressing of socket with medicated dressing	
E13.5	Closure of oroantral communication	OAF closure or OAC closure	

2. Other procedures involving teeth and orthodontic related procedures

Procedure descriptions and OPCS-4 codes for other tooth and orthodontic related procedures in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F14.5	Surgical exposure of tooth	Open exposure, with/without pack placement or closed exposure with bracket and chain	
F15.2	Bond of tooth	Use for orthodontic bracket bonded onto an accessible tooth	Exposure and bond
F12.1	Apicectomy of tooth	Surgical removal of apical portion of tooth root and placement of retrograde root filling material	
F14.6	Insertion of orthodontic screw	Placement of TADs (temporary anchorage devices)	
F14.7	Removal of orthodontic screw	Removal of TADs (temporary anchorage devices)	
F63.5	Splinting of teeth	Do not use in addition to reimplantation/following auto-transplantation/following repositioning as it is included with those. Only use if it is the only procedure carried out	
F08.2	Auto-transplant of tooth	Planned surgical auto-transplantation of any tooth Note: It is not necessary to code splinting in addition	
F08.3	Replanting of tooth	Reimplantation following trauma Note: It is not necessary to code splinting in addition	
F08.4	Repositioning of tooth	Repositioning following trauma	Reimplantation (F08.3)
F08.8		Do not use	

OPCS code	Procedure description	Inclusions and notes	Exclusions
F08.9		Do not use	
F63.1	Impression for denture		
F67.1	Impression for splint		

3. Soft tissue surgery

Procedure descriptions and OPCS-4 codes for soft tissue surgery in outpatient Oral Surgery, split into sections by site.

3.1 Lip

Procedure descriptions and OPCS-4 codes for lip surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F02.1	Excision of lesion of lip	Excisional biopsy Note: Removal of any lesion of lip extra or intra oral except salivary gland origin (mucocele) see salivary gland (F45.-)	Salivary gland (F45.-)
F02.1 + Y08.2	Laser excision of lesion of lip	Excisional biopsy Note: Removal of any lesion of lip extra or intra oral except salivary gland origin (mucocele) see salivary gland (F45.-)	Salivary gland (F45.-)
F02.2 + Y08.4	Laser ablation of lesion of lip		
F02.2 + Y13.2	Cryotherapy to lesion of lip		
F05.1	Frenectomy	Removal of excess tissue from lip and includes frenectomy	
F05.3	Suture of lip	Note: This should not be used for closure following another procedure, only use when it is the only procedure carried out	
F05.4	Removal of suture of lip		
F06.2	Biopsy of lesion of lip	Biopsy of lip Incisional biopsy	Excisional biopsy
F06.8 + Y22.9	Drainage of abscess of lip		

3.2 Gingiva

Procedure descriptions and OPCS-4 codes for gingiva surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F20.2	Excision of lesion of gingiva	Excisional biopsy	
F20.2 + Y08.2	Laser excision of lesion of gingiva	Excisional biopsy	
F20.8 + Y08.4	Laser ablation of lesion of gingiva		
F20.8 + Y13.2	Cryotherapy to lesion of gingiva		
F20.3	Biopsy of lesion of gingiva	Biopsy of gingiva Incisional biopsy	
F20.5	Suture of gingiva	Note: Only use if this is the only procedure carried out	Suture for surgical arrest of post-extraction bleeding (F16.2)
F20.8 + Y25.4	Removal of suture of gingiva		
F20.8 + Y22.9	Drainage of abscess of gingiva		

3.3 Tongue

Procedure descriptions and OPCS-4 codes for tongue surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F23.1	Excision of lesion of tongue	Excisional biopsy	
F23.1 + Y08.2	Laser excision of lesion of tongue	Excisional biopsy	
F23.2 + Y08.4	Laser ablation of lesion of tongue		
F23.2 + Y13.2	Cryotherapy to lesion of tongue		
F26.3	Incision of frenulum of tongue	Use for release of tongue tie	
F24.1	Biopsy of lesion of tongue	Biopsy of tongue Incisional biopsy	
F26.5	Suture of tongue		
F26.8 + Y25.4	Removal of suture of tongue		
F24.8 + Y22.9	Drainage of abscess of tongue		

3.4 Palate

Procedure descriptions and OPCS-4 codes for palate surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F28.1	Excision of lesion of palate	Excisional biopsy	
F28.1 + Y08.2	Laser excision of lesion of palate	Excisional biopsy	
F28.2 + Y08.4	Laser ablation of lesion of palate		
F28.2 + Y13.2	Cryotherapy to lesion of palate		
F30.7	Suture of palate		
F30.8 + Y25.4	Removal of suture of palate		
F32.1	Biopsy of lesion of palate	Biopsy of palate Incisional biopsy	
F32.3	Drainage of abscess of palate		

3.5 Floor of mouth

Procedure descriptions and OPCS-4 codes for floor of mouth surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F38.1	Excision of lesion of floor of mouth	Excisional biopsy Note: Any lesion in floor of mouth except salivary gland origin (mucocele) see salivary gland (F45.-)	
F38.1 + Y08.2	Laser excision of lesion of floor of mouth	Excisional biopsy Note: Any lesion in floor of mouth except salivary gland origin (mucocele) see salivary gland (F45.-)	
F38.3 + Y08.4	Laser ablation of lesion of floor of mouth	Note: Any lesion in floor of mouth except salivary gland origin (mucocele) see salivary gland (F45.-)	
F38.3 + Y13.2	Cryotherapy to lesion of floor of mouth	Note: Any lesion in floor of mouth except salivary gland origin (mucocele) see salivary gland (F45.-)	

3.6 Mouth not elsewhere classified (NEC) and neck

Procedure descriptions and OPCS-4 codes for soft tissue surgery on the neck and other defined areas of the mouth in outpatient Oral Surgery.

The term Not Elsewhere Classified (NEC) is used to indicate that there may be more accurate codes elsewhere. Only use the codes in this section for areas of the mouth that do not have more specific codes available.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F38.2	Excision of lesion of mouth NEC	Excisional biopsy Note: Only use if specific anatomical site not listed separately	
F38.2 + Y08.2	Laser excision of lesion of mouth NEC	Excisional biopsy Note: Only use if specific anatomical site not listed separately	
F38.4 + Y08.4	Laser ablation of lesion of mouth NEC	Note: Only use if specific anatomical site not listed separately	
F38.4 + Y13.2	Cryotherapy to lesion of mouth NEC	Note: Only use if specific anatomical site not listed separately	
F40.4	Suture of mouth NEC	Note: Only use if specific anatomical site not listed separately	
F40.5	Removal of suture of mouth NEC	Note: Only use if specific anatomical site not listed separately	
F42.1	Biopsy of lesion of mouth NEC	Biopsy of mouth not covered by a site specific code Note: Only use if specific anatomical site not listed separately Includes buccal mucosa	
F42.2 + Y22.9	Drainage of abscess of mouth NEC	Note: Only use if specific anatomical site not listed separately	
S47.1 + Z48.2	Drainage of abscess of neck (not salivary gland)		Drainage of abscess of salivary gland (F46.-)

3.7 Salivary gland

Procedure descriptions and OPCS-4 codes for salivary gland surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F45.1	Excision of lesion of parotid gland	Excisional biopsy	
F45.2	Excision of lesion of submandibular gland	Excisional biopsy	
F45.3	Excision of lesion of sublingual gland	Excisional biopsy	
F45.4	Excision of lesion of other salivary gland	Excisional biopsy	Parotid (F45.1) Submandibular (F45.2) Sublingual (F45.3)
F45.5	Destruction of lesion of salivary gland	Note: Add a site code to specify major gland (Z26.-)	
F46.1	Incision of parotid gland	Incision and drainage	
F46.2	Incision of submandibular gland	Incision and drainage	
F46.3	Incision of sublingual gland	Incision and drainage	

OPCS code	Procedure description	Inclusions and notes	Exclusions
F46.8	Incision of other salivary gland	Incision and drainage	Parotid (F46.1) Submandibular (F46.2) Sublingual (F46.3)
F48.1	Biopsy of lesion of salivary gland	Biopsy of salivary gland Incisional biopsy Note: Use for mucocele Note: Add a site code to specify major gland (Z26.-)	
F51.1	Open extraction of calculus from parotid duct	Open removal of calculus not endoscopic removal	Endoscopic removal (F56.1)
F51.2	Open extraction of calculus from submandibular duct	Open removal of calculus not endoscopic removal	Endoscopic removal (F56.2)
F55.1	Dilation of parotid duct		
F55.2	Dilation of submandibular duct		
F55.8	Dilation of other specified salivary duct (sublingual)		
F56.1	Manipulative removal of calculus from parotid duct	Removal of calculus not by an open approach e.g. **endoscopic** basket retrieval of calculus from duct	Open removal (F51.1)
F56.2	Manipulative removal of calculus from submandibular duct	Removal of calculus not by an open approach e.g. **endoscopic** basket retrieval of calculus from duct	Open removal (F51.2)

4. Temporomandibular Joint (TMJ) related

Procedure descriptions and OPCS-4 codes for TMJ procedures in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
V21.8 + Y22.3	Arthrocentesis of the temporomandibular joint		Arthroscopic arthrocentesis
V21.8 + Y76.7 + Y22.3	Arthroscopic arthrocentesis of the temporomandibular joint		
V21.8 + Y38.8	Therapeutic injection into temporomandibular joint		Arthroscopic injection
V21.8 + Y76.7 + Y38.8	Arthroscopic therapeutic injection into temporomandibular joint		
A70.6	Acupuncture		

5. Implants and pre-prosthetic surgery

Procedure descriptions and OPCS-4 codes for implants and pre-prosthetic surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F11.7	Endosseous implantation into zygoma	Placement of zygomatic implant	
F40.3	Graft of mucosa to mouth NEC	Can be used for split thickness grafting intraorally	
F11.1	Oral alveoplasty		
F11.2	Augmentation of alveolar ridge using bone autograft	Delayed augmentation	Augmentation of alveolar ridge using other graft materials (F11.3)
F11.3	Augmentation of alveolar ridge NEC	Delayed augmentation using other graft material	Augmentation of alveolar ridge using bone autograft (F11.2)
F19.2	Preservation of alveolar ridge using graft	Note: Use this code in addition to a code for dental extraction for concurrent preservation of alveolar ridge	
F11.5	Endosseous implantation into jaw	Use for placement of endosseous implant	Placement of TADs (temporary anchorage devices) (F14.6)
F11.9	Unspecified preprosthetic surgery of jaw	Only use if not covered with other pre-prosthetic procedures	

Note

The codes here provide useful detail on these procedures and will be sufficient in most cases. If delayed augmentation is carried out as a daycase and the clinical coding team is assigning codes using the full patient record they may record additional codes to show more detail on the type and source of the graft materials.

6. Maxilla and mandible – hard tissues related

Procedure descriptions and OPCS-4 codes for maxilla and mandible surgery in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
V13.8 + Y05.5 + Z64.4	Debridement of maxilla (for MRONJ)		
V19.8 + Y05.5	Debridement of mandible (for MRONJ)		
F18.1	Enucleation of dental cyst of jaw		
F18.2	Marsupialisation of dental lesion of jaw	Decompression of dental lesion	
F18.8		Do not use	
F18.9		Do not use	
F16.1	Drainage of abscess of alveolus of tooth	Incision and drainage of localised abscess Note: Active drainage rather than a secondary outcome of other treatment	

7. Miscellaneous

Procedure descriptions and OPCS-4 codes for miscellaneous procedures in outpatient Oral Surgery.

OPCS code	Procedure description	Inclusions and notes	Exclusions
F42.4	Photography of mouth	Note: Do not use this code if the patient is sent elsewhere for photography (i.e. out of the treatment room)	
F43.9	Examination of mouth	Note: Do not use this code in addition to any other procedure	

8. Subsidiary codes to specify site

Codes in this section should be used to add detail to the procedure descriptions and codes in the above code tables (where relevant). These subsidiary codes should be sequenced (entered) after the codes for the main procedure.

OPCS-4 code	Procedure description
Z26.1	Parotid gland
Z26.2	Submandibular gland
Z26.3	Sublingual gland
Z26.4	Salivary gland
Z26.5	Parotid duct
Z26.6	Submandibular duct
Z26.7	Salivary duct
Z25.2	Wisdom tooth
O36.1	Multiple teeth
Z94.3	Left side
Z94.2	Right side
Z94.1	Bilateral

9. Subsidiary codes for anaesthetic

Anaesthetics codes are particularly useful for hospital dentistry (including oral surgery) but are not routinely coded by clinical coding teams. It is recommended that anaesthetics codes are captured for hospital dentistry, both for local use and for national comparisons. We have successfully requested two new codes for specific types of sedation (see the table below) that can be used from 1st April 2023. Please use the anaesthetics codes in the following circumstances:

- Always add a code for general anaesthetic (GA) when GA is used
- Always add a code for sedation when it is used
- Use code Y84.2 (Oral/intranasal/other sedation) for sedation use when the type of sedation is not intravenous and not inhalation (or the sedation type is unknown)
- It is not necessary to code local anaesthetic (LA) for outpatient procedures. For daycases LA should be coded when it is the only anaesthetic method used

OPCS-4 code	Procedure description
Y80.9	General anaesthetic
Y84.3	Intravenous sedation
Y84.4	Inhalation sedation
Y84.2	Oral/intranasal/other sedation
Y82.2	Local anaesthetic injection

Procedures not included in the code tables

Destruction of a lesion by any method not covered in this guidance needs to be referred to your Clinical Coding Department for advice.

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Appendix

Important data items for outpatient activity

The sections in the appendix provide information on important data items that are relevant to outpatient activity in addition to the OPCS-4 procedure codes. Some of these data items affect trust income for dental activity.

The following data items are routinely recorded for outpatient attendances:

- Main Specialty of the responsible consultant and Treatment Function Code (TFC)
- Clinic type:
    - Single professional, multi-professional or multi-disciplinary
    - Consultant led and nurse led
    - Attendance type: first or follow-up appointment
    - Clinic names

It is important that these details are correctly recorded for each patient in order to accurately reflect time and resource use. Local trust information and/or finance teams will be able to provide an explanation of the way that your data are captured and examples of data recorded for your own activity. All of the above data items will affect the tariffs paid for providing oral surgery activity in outpatients.

Other relevant data items for outpatient activity and inpatient/daycase activity:

- Healthcare Resource Groups (HRGs) and tariffs
- ICD-10 diagnosis codes
- SNOMED Clinical Terms

Main specialty and TFC

Main specialty and Treatment Function Codes (TFC) are covered in the main section of this document (before the code tables).

Clinic types

Single professional, multi-professional or multi-disciplinary

Most outpatient clinics are set up as **single professional**. There will be local arrangements in place at your trust for some clinics to be set up as multi-professional (e.g. more than one oral surgeon) or **multi-disciplinary** (e.g. oral surgeon and one or more other consultants with a different main specialty, such as MDT with OMFS or Orthodontics). This data value is important (e.g. it can affect tariff income for the trust).

References in the NHS data dictionary: www.datadictionary.nhs.uk
Multi-Disciplinary Consultation (National Tariff Payment System) (datadictionary.nhs.uk)
Multi-Professional Consultation (National Tariff Payment System) (datadictionary.nhs.uk)

OPCS-4 procedure codes for multi- attendances

Part of the requirement for charging a tariff for multi-professional and multi-disciplinary attendances is that a specific OPCS-4 code is recorded for those attendances. Where this applies at the clinic level (for all attendances in a clinic) your trust may have standard (manual or electronic) processes in place. Where individual patient attendances need to be identified as multi-professional or multi-disciplinary (because the whole clinic is not already flagged as such) clinicians may be required to "tick a box" or use some other method of flagging these patients to the administration team.

Table: OPCS-4 codes for non-procedure attendances

OPCS-4 code description	OPCS-4 code
Assessment by uniprofessional team NEC	X62.1
Assessment by multiprofessional team NEC	X62.2
Assessment by multidisciplinary team NEC	X62.3

MDT clinics are run with allied specialists such as Restorative dentistry so the **X623** code is applied.

Consultant led and nurse led clinics

Within Outpatients care can be delivered in consultant led or nurse led clinics. It is important that clinics are set up with the correct healthcare professional, not least because tariff income will be different.

References in the NHS data dictionary: www.datadictionary.nhs.uk
Care Professional Out-Patient Attendance (datadictionary.nhs.uk)

Attendance type – first or follow up appointment

This is a data value captured for all outpatient attendances and is usually automatic: an outpatient episode consists of one or more attendances arising from a single referral. The first attendance is recorded as a first attendance; all subsequent attendances are recorded as follow up attendances. OPCS-4 codes are not used for this data.

Clinic names

Most outpatient systems set up individual clinics with a unique clinic name. Typically the clinic name will contain information about the nature of the clinic (e.g. using acronyms for important information) and will indicate some of the data values associated with that clinic (e.g. multi-disciplinary clinics, follow up or review clinics, etc.). Clinic names are not part of the national standard data set and so will vary between providers. Clinic names do not guarantee that the correct data items are being used for the attendances.

Using "review" to describe a clinic or a follow up attendance may have a local meaning but the word does not have a national definition. Attendance type is limited to **first attendance** and **follow up attendance.**

References in the NHS data dictionary: www.datadictionary.nhs.uk
FIRST ATTENDANCE (datadictionary.nhs.uk)

Healthcare Resource Groups (HRGs) and tariffs

Healthcare Resource Groups (fourth revision) is a grouping method used within Payment by Results (PbR), consisting of patient events that have been judged to consume a similar level of resource.

Each outpatient attendance is assigned one HRG value, which defines the tariff paid for that attendance. When OPCS codes are recorded for an attendance they used to calculate an individual HRG for that attendance. When no OPCS codes are present for an attendance an outpatient attendance HRG is assigned.

There are two main types of HRG for outpatient activity: outpatient attendance HRGs and procedure based HRGs.

Outpatient attendance HRGs

Where no procedure code is recorded for an outpatient attendance, the following data items will affect the tariff paid for the attendance:

- Main Specialty and Treatment Function Code
- Clinic type –
    - single professional, multi-professional or multi-disciplinary
    - consultant led or nurse led
- Attendance type – first or follow-up appointment
- Face to face or another consultation mechanism

It is important that these details are correctly recorded for each patient in order to accurately reflect time and resource use. Local trust information and/or finance teams will be able to provide an explanation of the way that your data are captured and examples of data recorded for your own activity. All of the above data items will affect the tariffs paid for providing oral surgery services in outpatients.

Procedure based HRGs

Where a procedure is carried out during an outpatient attendance, the HRG (and tariff value) will be derived from the OPCS-4 procedure codes assigned to that attendance. If more than one procedure (and more than one PROC code) is undertaken in a single outpatient attendance, only one HRG and therefore tariff is applicable. The grouper software, produced by NHS Digital, will determine the appropriate HRG, and the provider will claim the income at the relevant tariff. There are two tariffs for most procedure driven HRGs, split by age: patients 19 years and older; patients 18 years and under.

Procedure code accuracy

By accurately coding activity, the correct HRGs will be assigned and the tariff payments received will reflect the work provided. The activity can be quantified for services and this information can be used to support local and national discussions about service design, commissioning of services and workforce capacity.

References in the NHS data dictionary: www.datadictionary.nhs.uk

Healthcare Resource Group (datadictionary.nhs.uk)

ICD-10 diagnosis codes

The International Classification of Diseases version 10 (ICD-10) is the current diagnosis classification used in the NHS. ICD-11 has been published by the World Health Organisation and will be introduced for use in the NHS in the next few years (there is no firm date available; April 2026 is a likely introduction date).

ICD-10 diagnosis codes are mandatory for all inpatient episodes but are not routinely captured for outpatient attendances. This is unfortunate as using ICD-10 diagnosis codes would give us the scope to record the complexity of patients in secondary care.

Diagnosis codes can record the main condition treated and also medical comorbidities such as heart disease, respiratory conditions, diabetes, syndromes, etc. Dental morbidity could be captured, such as caries or periodontitis, as well as other definitions such as hypodontia, impacted teeth, etc. This would add to the auditability of our data and comparability between inpatient and outpatient activity.

SNOMED CT - systematised nomenclature of medicine (clinical terms)

SNOMED CT is the clinical vocabulary which is used to record consistent, reliable and comprehensive patient information as an integral part of an electronic patient record, facilitating a number of processes such as decision support, care pathway management and drug alerts. The Department of Health and Social Care has approved SNOMED CT as the single terminology of choice for health and care in England.

The diagnosis and procedures classifications described above are recorded as part of the administration dataset and are reported as part of the Commissioning Data Set (CDS). The detail contained in the clinical codes is designed to be useful when the data are used in aggregate, e.g. for characterising a collection of activity. Clinical codes do not have the detail necessary to record clinical information for individual patients at the clinical record level of detail. This is where SNOMED CT comes in. It is a clinical vocabulary readable by computers.

SNOMED CT is designed to capture clinical information in as much detail as necessary for use in a patient record. It is complementary to the classifications and has a different purpose.

SNOMED CT is mandated for use in electronic patient records but that does not mean that it is the only way that clinical data can be recorded: clinical codes are still permissible and relevant. In fact, Healthcare Resource Groups (HRGs) can only be derived from clinical codes and not from SNOMED CT codes. Clinical codes are mandated for use in the Commissioning Data Set (CDS) for outpatient care and admitted patient care. SNOMED CT relies on the adoption of electronic patient records (EPR) and will be increasingly adopted by hospitals as they implement EPR systems.

References in the NHS data dictionary: Commissioning Data Sets Overview (datadictionary.nhs.uk)

SNOMED CT - NHS Digital