Introduction

This special Coding Guideline has been published following a review of findings from the Data Quality Assessment of SMR02 in 2009.

A number of issues arose from the study and were discussed by the Maternity Data Development Alignment Working Group (MaDDAWG), with a view to improving the quality of the SMR02 data collected across Scotland.

A sub-group of MaDDAWG considered 82 items raised during the assessment and actioned 31 of those.

This guideline highlights those items which have been approved by the Clinical Coding Review Group, ISD. More importantly, it draws attention to those areas of the SMR02 data of which hospitals need to be aware. In some cases this will require a change to current practice by those recording and coding the data. A number of previously optional fields become mandatory (items 7 – 10), and this has been notified to the service by the normal Data Change Notice (DCN).

A new training manual for clinical coders will be available and sites can contact their Clinical Coding Tutors to arrange for a training or awareness session to suit their needs.

The Data Dictionary has also been updated where appropriate. Access to the Dictionary, which describes all SMR data items, their definitions and cross-checks, is available via the following link:

http://www.datadictionaryadmin.scot.nhs.uk/isddd/9215.html

If you have any queries regarding this Coding Guideline, please contact your Clinical Coding Tutor or call the Terminology Advisory Service:

Terminology Advisory Service; Tel. 0131 275 7283 Tuesday – Thursday 9.00am – 5.00pm or e-mail NSS.terminologyhelp@nhs.net
Data Items

1. Booking Date
Due to the various ways mums can now access maternity services, the definition of Booking Date is no longer appropriate. The new definition reflects the flexibility of the service, whilst allowing for consistency of recording.

Change to definition;
From: The booking date is the date on which the woman attends the antenatal booking clinic.
To: The booking date is the date of the first appointment where history is taken.

2. Analgesia During Labour and/or Delivery
Options have been expanded to include some of the newer complementary therapies.
More than one method of analgesia may be used in labour. The highest method in the following hierarchy should be used for coding this item:

General anaesthetic
Spinal (includes ‘combined spinal epidural’)
Epidural
Pethidine/Morphine or other opiates/opioids
Gas/Air
None

Codes and values
0 None
1 Pethidine/morphine or other opiates/opioids
2 Epidural
3 Gas and air only
4 General anaesthetic
5 Spinal (includes ‘combined spinal/epidural’)
8 Other
9 Not known

Code 8 should be used for other types of analgesia such as TENS, water births and other complementary medicines.
Coders should note that it is not necessary to record spinals and epidurals in the OPCS4 Clinical Section of the SMR02.
3. **Mode of Delivery – Babies 1 to 3**

The use of forceps has changed over the years. This has resulted in a re-classification of ‘Haig-Ferguson’ forceps. Previously, these would have been recorded as ‘low forceps’ (Code 2), but these are now considered to be ‘mid cavity forceps’ and must be recorded as ‘A’. See Codes and Values below:

**Codes and Values: Delivery**

- **0** Normal, spontaneous vertex delivery, occipito-anterior.
- **1** Cephalic vertex delivery, with abnormal presentation of the head at delivery, without instruments, with or without manipulation
- **2** Low forceps, no rotation, forceps NOS. *(incl Wrigley's)*
- **5** Breech delivery, spontaneous, assisted or unspecified partial breech extraction.
- **6** Breech extraction, NOS. Version with breech extraction.
- **7** Elective (planned) caesarean section.
- **8** Emergency and unspecified caesarean section.
- **9** Other and unspecified method of delivery.
- **A** Mid cavity forceps, no rotation *(incl Haig Ferguson, Neville-Barnes e.g.)*
- **B** Rotational forceps *(incl Kiellands)*
- **C** Ventouse, no rotation or unspecified
- **D** Ventouse with rotation

When coding forceps, where the term, ‘low’, ‘mid’ or ‘high’ cavity is mentioned, this should take priority over the type of forceps.

Code 2 - should be used when forceps are specified, but no further information is provided (i.e. forceps NOS); also for Wrigley’s Forceps, where no note of the position of the forceps is available. *(Haig-Ferguson forceps will now be considered as usually denoting mid cavity).*

If more than one type of forceps is used, only the most resource intensive should be recorded. Code B – Rotational is most important, followed by A – Mid cavity and lastly, 2 – Low forceps, no rotation.

Coders should be aware that a woman for whom a caesarean section is planned may go into labour and require an emergency caesarean section. This would be coded to ‘8’.

4. **Duration of labour**

Duration of labour is the length of time the state of labour lasts from its onset to the delivery of the placenta, expressed as the **number of completed hours**.

Please note that the **total time of the three stages of labour** should be rounded down to the complete hour to give a total duration of labour.

**Example:**

- **Stage 1** 3 hrs 59
- **Stage 2** 1 hr 36
- **Stage 3** 15mins
- **Total** 5hrs 50 = **5hrs total**

Time must also be recorded for an Emergency Caesarean Section where patient has undergone stages 1 and 2 of labour before the operation.
5. **Apgar score – Babies 1 - 3**

Apgar score is almost always documented and is a mandatory field. The code ‘RR’ should be used if the baby is being actively resuscitated at the 5 minute check, to indicate that the Apgar score cannot be accurately taken.

6. **Tears**

During the SMR02 Review, it was noted that there was an element of double coding and under-coding against this data item. It is hard-coded, but some sites were adding an ICD10 code where lacerations and tears were both recorded.

Although the data item is ‘tears’ and the ICD10 index trail is also ‘tear’, in fact the description for O70.- is “Perineal laceration during delivery”. ‘Minor’ (i.e. cervical and vaginal) lacerations are recorded under “Other obstetrical trauma” at O71.-. For this reason, perineal tears only are now recorded in the table.

Where vaginal and cervical lacerations are present, these should be coded in the diagnostic section using O71.4 and O71.3 respectively.

If there is only a vaginal or cervical laceration and no tear of perineum, record ‘0’ in the data item. See table below.

**Codes and Values: Tear (Code order)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No (includes intact perineum and/or vaginal and cervical lacerations)</td>
</tr>
<tr>
<td>1</td>
<td>Tear 1 (1st Degree)</td>
</tr>
<tr>
<td>2</td>
<td>Tear 2 (2nd Degree)</td>
</tr>
<tr>
<td>3</td>
<td>Tear 3 (3rd Degree)</td>
</tr>
<tr>
<td>4</td>
<td>Tear 4 (4th Degree)</td>
</tr>
<tr>
<td>5</td>
<td>Vaginal lacerations – removed from options</td>
</tr>
<tr>
<td>6</td>
<td>Cervical lacerations – removed from options</td>
</tr>
<tr>
<td>8</td>
<td>Unspecified tear</td>
</tr>
<tr>
<td>9</td>
<td>Not known if tear</td>
</tr>
</tbody>
</table>

7. **Weight of Mother at Booking.**

This data item will become mandatory on 1st April 2011.

8. **Height.**

This data item will become mandatory on 1st April 2011.

9. **Typical Weekly Alcohol Consumption.**

This data item will become mandatory on 1st April 2011.

10. **Drugs Misuse During This Pregnancy.**

This data item will become mandatory on 1st April 2011.

Please note, although it may be April 2011 before data items are made mandatory on systems, coders should complete these fields forthwith.
Clinical Coding Section

11. Premature Rupture of Membrane (PROM) O42.-
This means rupture of membranes before onset of labour (contraction stage) regardless of the length of gestation. The fourth-character identifies the length of time before the onset of labour. This code is classified within the section on maternal care related to the fetus and amniotic cavity and possible delivery problems.

For Scotland, it is important to record this on the delivery episode, even if it happened earlier. This is to ensure all PROMs are recorded, as it may have occurred outwith the hospital. This may mean an element of double counting, as the PROM event must also be coded in any ante-natal stay where the patient has been treated for that condition.

12. Anti-D
Anti-D can be given to a Rhesus negative mother in the antenatal period as well as in the postnatal period. Anti-D is always given by intramuscular injection.

Record in both ICD10 and OPCS4.
ICD10 – Z29.1 Prophylactic immunotherapy
OPCS4 – X30.1 Injection of rh immune globulin
If it is known that Anti-D is given in the delivery episode, code both ICD10 and OPCS4. However, if it is unclear when the Anti-D was administered during the pregnancy, only the ICD10 code is required and must be coded in the delivery episode.

13. Retained placenta
O72.0 Third-stage haemorrhage
- In ICD10 O72.0 includes Retained placenta NOS.

However, in Scotland, it has been agreed that in cases of retained placenta where haemorrhage is not mentioned OR where the blood loss is recorded as < 500mls, the retained placenta should be coded to:

O73.0 – Retained placenta without haemorrhage.

Please annotate ICD index as follows;

Retention
- placenta (total) (with haemorrhage) O72.0
  -- portions or fragments (with haemorrhage) O72.2
    --- without haemorrhage O73.1 (retained portions of placenta NOS)
  -- without haemorrhage O73.0 (Retained placenta NOS)

Even though ‘without haemorrhage’ is an essential modifier, code Retention of placenta NOS to O73.0 where there is no specific mention of haemorrhage OR where the blood loss is < 500mls.

The same rule applies to Retained portions of placenta and membranes, without haemorrhage at O73.1.
There is also another index trail, which should be annotated in the same way;

**Placenta**
- retention (with postpartum haemorrhage) O72.0
  -- fragments, complicating puerperium (delayed haemorrhage) O72.2
    --- without haemorrhage O73.1 (*retained portions of placenta NOS*)
  -- without haemorrhage O73.0 (*Retained placenta NOS*)

14. **Intrapartum vs. Postpartum haemorrhage**

Blood loss is likely to be from postpartum cause, rather than intrapartum.

**Intrapartum haemorrhage** - between the beginning and end of labour. O67.- Intrapartum haemorrhage, must only be recorded where the term ‘intrapartum haemorrhage’ is specifically used.

**Postpartum haemorrhage** - after the baby is delivered. The code O72.- Postpartum haemorrhage must be recorded in all cases where either a) the clinician states ‘postpartum haemorrhage’ or b) the clinician makes no statement of intra- or postpartum haemorrhage, but blood loss is recorded as 500mls or more. (Includes haemorrhage occurring during a Caesarean section.)

15. **Fetal distress:**

Coders must not record the terms ‘suspicious CTG’ (*Cardiotocography*), ‘Non-reassuring CTG’ or ‘Suboptimal CTG’.

However, if the patient went on to have an operative delivery due to these signs, then the code O68.8 – *Labour and delivery complicated by other evidence of fetal stress* should be recorded in the Indication for Operative Delivery field.

The code O68.8 – *Labour and delivery complicated by other evidence of fetal stress* must be used to code the terms ‘Pathological CTG’ and ‘Abnormal CTG’, where present.

16. **Precipitate labour O62.3**

As there are varying definitions of this (undue speed of labour to delivery), it is not advisable to use the code unless the particular term has been stated.

17. **Hypertension and raised BP in pregnancy:**

Clarification of when to code hypertension and raised BP in pregnancy.
- Hypertension should only be coded when a clinician explicitly states that the mother has hypertension. Then a code from O10.-, O13.X, or O16.X can be selected as appropriate.
- Coders should not search for and analyse blood pressure readings, and should not look for the “^BP” symbol (elevated blood pressure) written in the available clinical material, with a view to recording any code whatsoever.
- the code R03.0 can be recorded if there is an explicit clinical statement that the mother was admitted because of raised blood pressure or that raised blood pressure was a significant concern during the admission. R03.0 should only be used if there is no definitive diagnosis given as the cause of raised blood pressure.
18. **Multiple gestation O30**
A code from category **O30 Multiple gestation** should be coded as the primary diagnosis for Ante-natal episodes, (where appropriate) but on an SMR02 Delivery episode, it is not required, as this information is collected in the delivery data items. Where no other relevant obstetric condition exists, the main condition should be recorded as O84.0 – multiple delivery, all spontaneous.

19. **Preterm delivery O60.X**
This is a delivery before 37 completed weeks of gestation. It is not necessary to use this code in Scotland, as the information regarding gestation is collected elsewhere. Where no other relevant obstetric condition exists, in a delivery episode, the main condition must be recorded as O80.0 – Spontaneous vertex delivery.

20. **Anaemia complicating pregnancy, childbirth and the puerperium O99.0**
O99.0 Anaemia complicating pregnancy, childbirth and the puerperium can only be used in the first position. When using code **O99.0**, this must be used alone when the anaemia is unspecified. O99.0 should be followed by a code from **D50–D64.8** when the cause of the anaemia is known. Haemoglobin levels are slightly lower than usual in pregnancy; therefore care must be taken only to code ‘anaemia in pregnancy’ when clearly defined in the patient’s medical record by the obstetrician or midwife. Statements of “low hb” or “sent home on iron tablets” should not be coded as anaemia.

If there is another obstetric condition to be recorded in Main Condition and the coder needs to record the clinical text “anaemia”, a code from Chapter III (blocks D50-D64) should be recorded in Other Conditions. Where the type of anaemia is not known record **D64.9 Anaemia, unspecified**.

21. **Hard Coded Diagnostic and Procedure Fields on SMR02**
There are 7 hard coded items which have ICD/OPCS4 equivalents:

- Type of Abortion
- Management of Abortion
- Induction of Labour
- Sterilisation after Delivery
- Episiotomy
- Tears
- Mode of delivery

These hard coded items (i.e. assigned special non-ICD10 OPCS4 codes) are required by ISD. However, these codes have ICD10 or OPCS4 equivalents which may be more specific than the hard codes. Where the data is hard coded there is no need to duplicate the information by coding again in the diagnostic section unless the ICD10/OPCS4 code gives more specific information (e.g. lower uterine segment caesarean (LUSC) at R17.2 and R18.2).

The exception to this rule is when codes O80.- to O84.- are used as there are no other obstetric conditions to record.

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**THESE GUIDELINES APPLY TO ALL DISCHARGES FROM 1ST OCTOBER 2010.**
Contact
Please note that the Terminology Advisory Service Telephone Number is 0131-275-7283.
The number is manned Tuesday to Thursday from 09.00 to 17.00 hrs.
The link for previous coding guidelines online is: www.isdscotland.org/terminology