Scottish Clinical Coding Standards - ICD10

Acute Coronary Syndrome

In response to a recent clinical coding standard issued by HSCIC in England, the Clinical Coding Review Group has decided that “Acute Coronary Syndrome NEC” must be coded to I24.9.

Please amend your ICD10 V4 Volume 3 Index as follows:

Page 602
Syndrome
- coronary
- - acute NEC I24.9

Myocardial Infarction and unstable angina – Updated Standard

In June 2007 ISD published a guideline on ‘Coding The Acute Coronary Syndromes Using ICD10’ (CG20) to help coders deal with clinical statements associated with the term ‘acute coronary syndrome’. The main feature of the 2007 guideline was the introduction of a fifth digit for use with I20.0 Unstable angina. This fifth digit was used to record clinical statements describing the levels of troponin (a biochemical marker of myocardial damage) found in the patient’s blood.

The Scottish Cardiac Society has now adopted a new, international definition of myocardial infarction (MI). This new definition should have the effect of simplifying the terminology encountered by coders when coding MI patients in Scotland. This guideline outlines the statements most likely to be encountered and clarifies how they should be coded:

1) Unstable angina - this should be coded I20.0 Unstable angina, exactly according to ICD10 rules and conventions.

(NOTE that coders no longer need look for, or take account of, clinical statements describing blood troponin levels. The 5th digits signifying “troponin status” which were applied to I20.0 in the 2007 guideline are no longer applicable. This is because unstable angina is always “troponin-negative” by the new definition).

2) ST elevation myocardial infarction (STEMI) and Non-ST elevation myocardial infarction (NSTEMI) – clinicians will usually classify an MI as either a STEMI or NSTEMI. It is clinically important to distinguish between these two types of MI, and consequently it is also important to record them in coded SMR data.
“ST elevation” and “non-elevation” refer to the appearance of a part of the patient’s electrocardiogram (ECG) trace. The ICD10 index and the categories I21.- Acute myocardial infarction and I22.- Subsequent myocardial infarction make no explicit mention of ST elevation or non-elevation. Coders will be aware that the sub-categories of I21.- and I22.- classify MIs according to another feature of the patient’s ECG trace, namely the identification of the area of the myocardium affected – anterior wall, inferior wall etc. (NOTE that it is clinicians who are responsible for the interpretation of ECG traces. Coders are responsible only for the coding of clinical statements made after such interpretation).

The need to record STEMI and NSTEMI must fit in with the existing structure of the ICD10 codes for MI. This will be done by adding a 5th digit for use ONLY with codes I21.- Acute myocardial infarction and I22.- Subsequent myocardial infarction.

Coders should add a fifth digit from Table 1 whenever they use codes I21.- and I22.-.

**Table 1**

<table>
<thead>
<tr>
<th>Fifth digit</th>
<th>Meaning of fifth digit for I21.- and I22.- ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Non-ST Elevation Myocardial Infarction (NSTEMI)</td>
</tr>
<tr>
<td>1</td>
<td>ST Elevation Myocardial Infarction (STEMI)</td>
</tr>
<tr>
<td>9</td>
<td>MI with no statement of ST elevation or non-elevation</td>
</tr>
</tbody>
</table>

To use these 5th digits with I21.- and I22.-, the MI should first be coded as usual, taking into account available information about any previous MIs and about the area of the myocardium affected – anterior, inferior etc. (NOTE that the essential modifier ‘transmural’ which is found in the index trail leading to I21.- Acute myocardial infarction can be ignored. This is because it is unlikely to appear in clinical statements). The 5th digit signifying NSTEMI, STEMI or ‘no statement’ should then be added.

Examples (assuming that this is the patient’s first MI) are shown in Table 2.

**Table 2**

<table>
<thead>
<tr>
<th>Example of clinical statement to be coded</th>
<th>ICD10 code</th>
<th>Fifth digit</th>
<th>Final code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior NSTEMI</td>
<td>Anterior MI = I21.0</td>
<td>NSTEMI = 0</td>
<td>I21.00</td>
</tr>
<tr>
<td>Anterior STEMI</td>
<td>Anterior MI = I21.0</td>
<td>STEMI = 1</td>
<td>I21.01</td>
</tr>
<tr>
<td>Anterior MI</td>
<td>Anterior MI = I21.0</td>
<td>no statement = 9</td>
<td>I21.09</td>
</tr>
<tr>
<td>NSTEMI</td>
<td>MI unspecified = I21.9</td>
<td>NSTEMI = 0</td>
<td>I21.90</td>
</tr>
<tr>
<td>STEMI</td>
<td>MI unspecified = I21.9</td>
<td>STEMI = 1</td>
<td>I21.91</td>
</tr>
<tr>
<td>MI</td>
<td>MI unspecified = I21.9</td>
<td>no statement = 9</td>
<td>I21.99</td>
</tr>
</tbody>
</table>

3) **Aborted MI** - this should be coded as I24.0 Coronary thrombosis not resulting in myocardial infarction.

4) The phrase “acute coronary syndrome” should no longer appear as the sole, definitive, diagnostic statement. It may appear as a generic, descriptive term in the clinical information used by the coder. However it should be accompanied by more specific information i.e. “unstable angina”, “NSTEMI” or “STEMI”. The coder should code the more specific information according to this guideline.
If “acute coronary syndrome” is the only clinical statement about the acute cardiac event which is available to the coder then:

- firstly the coder should seek clarification from the clinician about how the case should be classified according to the rules in this guideline.
- ONLY if clarification cannot be obtained, then the phrase “acute coronary syndrome” should be coded to I24.9 Other forms of acute ischaemic heart disease.

[The code for “acute coronary syndrome” unspecified has been changed from I24.8 to I24.9 in line with the new guideline ‘Acute Coronary syndrome’ in SCCS 8 September 2014.]

**Developmental dysplasia of the hip**

The clinical term ‘Congenital Dislocation of the Hip’ is no longer routinely used in Scotland. The term ‘Developmental Dysplasia of the Hip (DDH)’ is now used instead. ICD10 coding rules do not yet reflect this change in terminology, in particular the use of ‘developmental’ rather than ‘congenital’. This coding guidance is to confirm that ICD10 code Q65 should be used for patients noted as having Developmental Dysplasia of the Hip (DDH) as well as any that are still noted as having Congenital Dislocation of the Hip.

Q65.0, Q65.1, or Q65.2 should be used if a patient is noted as having DDH with a dislocated hip.

Q65.3, Q65.4, or Q65.5 should be used if a patient is noted as having DDH with a subluxated hip.

Q65.6 should be used if a patient is noted as having DDH with an unstable, dislocatable, or subluxatable hip.

Q65.8 should be used if a patient is noted as having DDH with no further details provided.

Q65.9 should be used if a patient is noted as having a congenital deformity of the hip with no further details provided.

Note that children noted as having ‘clicky’ or ‘clicking’ hips, with no mention of DDH, should continue to be coded to R29.4.

**Use of ICD10 codes ‘U80-U89 Bacterial agents resistant to antibiotics’**

The Clinical Coding Review Group (CCRG) has agreed that it is not necessary to use ICD10 codes U80 –U89 in Scotland.

U80-U89 may be used locally if required, but relevant comorbidities\(^1\) should take precedence over any codes from U80–U89 in nationally submitted SMR01 data. If any space is left after recording comorbidities and other necessary codes, the appropriate code(s) from U80-U89 may be recorded if desired.

\(^1\) see Coding Guidelines 21, November 2007 ‘Other Conditions coding on SMR01’ available from Coding Guidelines.

**Female Genital Mutilation**

There is a great deal of interest in Female Genital Mutilation (FGM) and the Scottish Government have recently written to medical and nursing staff to instruct them to document (on discharge summaries and in case notes) all cases coming into contact with the services in order that figures can be monitored.

FGM involves all procedures involving the partial or total removal of the external female genital organs for cultural reasons or other injury to the female genital organs for non-therapeutic reasons. The practice is medically unnecessary, extremely painful, and has serious health consequences, both at the time when the mutilation is carried out and in later life.
There are no specific codes as yet within ICD10 to clearly represent this condition.

The two codes which must be used together to code the clinical statements “Female Genital Mutilation” or “FGM” or “clitoridectomy” or “infibulation” are:

**N90.8 Other specified noninflammatory disorders of vulva and perineum**

And

**Z87.4 Personal history of diseases of the genitourinary system**

Whilst these codes cannot exclusively identify FGM patients, they will, in the event of enquiries, enable records to be audited quickly.

In addition, there are two new codes in OPCS4.7 which are used to record the initial corrective procedure for FGM:

**P07.2 Deinfibulation of vulva**

**R27.2 Deinfibulation of vulva to facilitate delivery**

P07.2 is for use on SMR01, whilst R27.2 would be expected on an SMR02.

Coders should ensure the information is captured on the SMRs in this manner. If you have any queries regarding this standard, please contact the Terminology Advisory Service.
**ICD-10 4th Edition Errata**

HSCIC in England has identified and been informed of further errata in ICD10 V4. These are listed in the tables below. Please amend your ICD10 V4 books accordingly.

**ICD-10 4th Edition Volume 3 - Alphabetical Index changes in 03/2014 update – For implementation from 01/04/2014**

<table>
<thead>
<tr>
<th>Page</th>
<th>Instruction</th>
<th>Action (Underline – insert text, Strikethrough – delete text)</th>
</tr>
</thead>
</table>
| 200-201 | Delete codes | Diabetes, diabetic (mellitus) (controlled) (familial) (severe) E14.-  
– acetonemia – code to E10-E14 with fourth character .1E14.1  
– acidosis – code to E10-E14 with fourth character .1E14.1  
– bone change – code to E10-E14 with fourth character .6E14.6M90.8  
– cataract – code to E10-E14 with fourth character .3E14.3H28.0  
– coma (hyperglycemic) (hyperosmolar) – code to E10-E14 with fourth character .0E14.0  
– gangrene – code to E10-E14 with fourth character .5E14.5  
– intracapillary glomerulosclerosis – code to E10-E14 with fourth character .2E14.2N08.3  
– iritis – code to E10-E14 with fourth character .3E14.3H22.1  
– ketosis, ketoacidosis – code to E10-E14 with fourth character .1E14.1  
– nephropathy – code to E10-E14 with fourth character .2E14.2N08.3  
– nephrosis – code to E10-E14 with fourth character .2E14.2N08.3  
– neuralgia – code to E10-E14 with fourth character .4E14.4G63.2  
– neuritis – code to E10-E14 with fourth character .4E14.4G63.2  
– neuropathy E14.4† G63.2*  
– – peripheral autonomic – code to E10-E14 with fourth character .4E14.4G99.0  
– retinal hemorrhage – code to E10-E14 with fourth character .3E14.3H36.0  
– retinitis – code to E10-E14 with fourth character .3E14.3H36.0  
– retinopathy – code to E10-E14 with fourth character .3E14.3H36.0 |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 207  | Delete code | **Disease, diseased**—continued  
...  
– dense deposit – code to N00-N07 with fourth character .6N05.6 |
| 219  | Delete code | **Disorder** – *continued*  
...  
– amnesic, amnestic  
...  
– drug-induced – code to F11-F19 with fourth character .6F1X.6 |
| 237  | Delete code | **Drug**  
...  
– harmful use – code to F10-F19 with fourth character .1F1X.1 |
| 299  | Delete code | **Glomerulonephritis** – *continued*  
...  
– membranoproliferative (diffuse) (type 1) (type 3) – code to N00-N07 with fourth character .5N0.5 |
| 333  | Delete cross reference | **Hypertension, hypertensive**—*continued*  
...  
– heart (disease) (conditions in I51.4-I51.9 due to hypertension) I11.9  
– – with  
– – – heart failure (congestive) (see also Hypertension, heart) I11.0 |
| 504-505 | Add/delete lead term | **Paterson(-Brown)-Kelly syndrome** D50.1  
**Pathologic, pathological**  
- fire-setting F63.1  
- gambling F63.0  
- ovum O02.0  
**Paterson(-Brown)-Kelly syndrome** – *continued*  
- stealing F63.2 |
| 602  | Amend code | **Syndrome**—*continued*  
...  
– coronary  
– – acute NEC I24.9I20.0I24.9 |
<table>
<thead>
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<th>Instruction</th>
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</tr>
</thead>
</table>
| 117  | Delete note | A41.9  Sepsis, unspecified  
*Note:* Use additional code (R57.2) if desired to identify septic shock  

Septic shock  

Septicaemia |
| 233  | Amend note  | D63.8*  Anaemia in other chronic diseases classified elsewhere  
Anaemia in chronic kidney disease ≥ stage 3 (N18.3-N18.59†) |
| 454  | Amend note  | I98.2*  Oesophageal varices without bleeding in diseases classified elsewhere  
Oesophageal varices without bleeding in:  

• liver disorders (K70-K71†, K74.-†)  

• schistosomiasis (B65.-†)  

I98.3*  Oesophageal varices with bleeding in diseases classified elsewhere  
Oesophageal varices with bleeding in:  

• liver disorders (K70-K71†, K74.-†)  

• schistosomiasis (B65.-†) |
| 612  | Delete/add notes | N18  Chronic kidney disease  
*Incl.:* chronic uraemia  

diffuse sclerosing glomerulonephritis  

N18.5  Chronic kidney disease, stage 5  
chronic uraemia  

N18.9  Chronic kidney disease, unspecified  

Chronic renal impairment  

Chronic uraemia NOS  

Diffuse sclerosing glomerulonephritis NOS |
| 774  | Delete note  | R57  Shock, not elsewhere classified  
*Excl.:* shock (due to):  

...  

• septic (A41.9) |
**Date of Operation**

Recently, Coding Departments were contacted to ask about recording of ‘Date of Operation’. The Scottish Hip Fracture Audit (SHFA) had found that ‘Date of Operation’ on SMR01s, in comparison to data gathered directly from patient case notes, was inaccurate to an average of 26%. In some hospitals, the error rate was 50 – 70%.

It appeared that some hospitals did not have access to the operation date and were therefore using the admission date, or admission date ‘plus one’ as a default. As this ‘Date of Operation’ is used to monitor a HEAT target which aims to show 98% of eligible patients are taken to theatre within 48 hours of admission, inaccuracy of the data item affects the HEAT target.

In discussions with coders in hospitals, it would appear that there are still some difficulties in accessing the information – either due to unavailability of case records or no access to theatre systems.

We would encourage coders to discuss this issue with their managers to ensure that they have access to this information and that all discharge summaries have ‘Date of Operation’ on the template for completion, as recommended by the Scottish Intercollegiate Guidelines Network, (SIGN) Guidelines.

Further information about the SHFA can be found at:


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**PLEASE NOTE THAT CLINICAL COSING STANDARDS IN THIS EDITION APPLY TO ALL DISCHARGES ON AND AFTER 1ST OCTOBER 2014.**

**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 standards/guidelines online is: [www.isdscotland.org/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines](http://www.isdscotland.org/Products-and-Services/Terminology-Services/Clinical-Coding-Guidelines)

**Scottish Clinical Coding Standards is the new title for Coding Guidelines.** This is to reflect the fact that the standards published herein are coding rules which apply in Scotland.

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