

SCOTTISH CLINICAL CODING STANDARDS - ICD10

Factor V Leiden

Factor V Leiden is the name of a specific gene mutation that results in thrombophilia which is an increased tendency to form abnormal blood clots that can block blood vessels.

This is often incorrectly referred to as 'Factor V Leiden deficiency'.

ICD-10 V4 (2010 Edition) includes a new code which covers this disorder :

D68.5 – Primary thrombophilia

An inclusion term in the Tabular is:

Activated protein C resistance [factor V Leiden mutation].

The only way this can be accessed through the index is via the term 'mutation' (P429);

Mutation

- prothrombin gene (factor V Leiden mutation) D68.5

Coders should insert an entry for this disorder under 'Leiden' to help assign the correct code.

Heart failure coding – fifth digits and clinical outcomes

The **Scottish Patient Safety Programme** and **Health Improvement Scotland** have been working with **NHS Boards** to implement a Heart Failure Care Bundle (a set of recommended clinical practices aimed at improving acute care outcomes for heart failure patients)^a. Coded SMR01 data can play a valuable part in measuring some of these outcomes. However to do this the data must capture information about heart failure which cannot be captured using ICD10 codes alone. This standard describes the extra information required, and shows how to code it.

1 What extra information is required?

Patients with a diagnosis of heart failure can be broadly divided into two groups:

- those who have a **reduced left ventricular ejection fraction**^b
- those who have a **preserved ejection fraction** i.e. the left ventricular (LV) ejection fraction is within normal limits.

Contents

Scottish Clinical Coding Standards - ICD10	1
Factor V Leiden.....	1
Heart failure coding – fifth digits and clinical outcomes ...	1
Rectus Sheath Haematoma	4
Scottish Clinical Coding Standards – OPCS4	4
Application of patches (Fentanyl, Qutenza)	4
General Information	5
Scottish Morbidity Record (SMR) and Hospital Standardised Mortality Ratios (HSMR)	5
SMR04 Discharge Diagnoses	5

It is this information about the LV ejection fraction which must be captured. This will be done by adding a Scottish fifth digit to certain relevant ICD10 codes. The fifth digits are:

Table 1

Fifth digit	Description of LV function
0	Reduced Ejection Fraction
1	Preserved Ejection Fraction
9	No information on ejection fraction

Note that it is important to record cases where there is no information about LV function available to coders. These should be recorded with fifth digit 9.

2 Which diagnoses require the fifth digit?

The fifth digit must be recorded in cases with a **stated diagnosis** of heart failure or certain types of cardiomyopathy. The diagnosis codes requiring the 5th digit are:

Table 2

ICD-10 Code	Description
I11.0	Hypertensive heart disease with (congestive) heart failure
I13.0	Hypertensive heart and renal disease with (congestive) heart failure
I13.2	Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
I25.5	Ischaemic cardiomyopathy
I42.0	Dilated cardiomyopathy
I42.9	Cardiomyopathy, unspecified
I50.0	Congestive heart failure
I50.1	Left ventricular failure
I50.9	Heart failure, unspecified

Doctors recording such diagnoses will often (not always) include information describing LV ejection fraction. This information (or the lack of it) should ALWAYS be recorded by using the appropriate fifth digit from **Table 1** with any of the ICD10 codes in **Table 2**.

To use the fifth digits:

- firstly, code stated diagnoses of heart failure or cardiomyopathy according to normal ICD10 rules and coding standards
- then, if the resulting ICD10 code appears in Table 2, add the appropriate fifth digit from Table 1
- note that Table 2 does not include all possible ICD10 codes for heart failure or cardiomyopathy. The fifth digits should only be used with the codes in the table.

3 Clinical language describing LV function

Unfortunately the clinical language used to describe LV function is not standardised to 'reduced ejection fraction' or 'preserved ejection fraction'. This makes the coder's job more difficult. Doctors may use other terms instead of, or as well as, these phrases. These other terms are listed below:

- **Reduced Ejection Fraction – other terms**

For coding purposes any of the following descriptions should be regarded as being synonymous with 'reduced ejection fraction':

Left ventricular

- dysfunction
- systolic dysfunction (LVSD)
- systolic impairment

Impaired or reduced

- LV function
- LV systolic function
- systolic function

- **Preserved Ejection Fraction – other terms**

For coding purposes any of the following descriptions should be regarded as being synonymous with 'preserved ejection fraction':

Preserved

- LV function
- systolic function

Normal

- ejection fraction
- LV function
- systolic function

Note that 'Diastolic heart failure' is heart failure with preserved ejection fraction.

4 Clinical statements describing LV function WITHOUT a stated diagnosis of heart failure or cardiomyopathy

- If a patient who DOES NOT have a stated diagnosis of heart failure or cardiomyopathy is described by the clinician as having a 'reduced ejection fraction' (or a synonymous phrase listed above), the reduced ejection fraction (or synonym) should be recorded by adding **fifth digit 0** to the following R code:

R93.1 Abnormal findings on diagnostic imaging of heart and coronary circulation

e.g. clinical statements of 'left ventricular systolic dysfunction (LVSD)' or 'reduced ejection fraction' (where there is no stated diagnosis of failure or cardiomyopathy) would be coded as R93.10.

- If a patient who DOES NOT have a stated diagnosis of heart failure or cardiomyopathy is described as having a 'preserved ejection fraction' (or a synonymous phrase listed above), NOTHING need be recorded.

5 Abbreviations which may be encountered

		coding
HFREF	Heart Failure with reduced ejection fraction	I50.90
HFPEF	Heart Failure with preserved ejection fraction	I50.91
HFPSF	Heart Failure with preserved systolic function	I50.91
LVREF	Left ventricular reduced ejection fraction (if no failure/cardiomyopathy stated)	R93.10
LVSD	Left ventricular systolic dysfunction (if no failure/cardiomyopathy stated)	R93.10

6 Obsolete coding guidance

Coding Guidelines No.2, January 1999 'Left Ventricular Dysfunction' stated "left ventricular dysfunction should be coded to I50.1 Left ventricular failure". This 1999 guidance is now completely superseded by the present standard.

This means that

- the phrase 'left ventricular dysfunction' used in isolation without a stated diagnosis of heart failure or cardiomyopathy should NOT be coded to I50.1. Instead it should be coded to R93.10 (see 4).
- the phrase 'left ventricular dysfunction' used with a stated diagnosis of heart failure or cardiomyopathy should be coded by adding the fifth digit 0 to the appropriate ICD10 code for the stated diagnosis.

a [Health Improvement Scotland Heart Disease Service Review 2011](#)

b The contraction (systole) of a filled ventricle does not expel all of the blood it contains. The *ejection fraction* is a measure of the proportion of the blood which is actually expelled from the ventricle.

Rectus Sheath Haematoma

There is no specific ICD10 index trail for Rectus Sheath Haematoma (RSH). The index trail

Hematoma (traumatic) (skin surface intact) (*see also* Injury, superficial) T14.0

- muscle - *code as* Contusion, by site

Contusion (skin surface intact) (*see also* Injury, superficial) T14.0

- abdomen, abdominal (muscle) wall S30.1

leads to the injury code **S30.1 Contusion of abdominal wall**. This has caused confusion because many cases of RSH are described as 'spontaneous' or 'non-traumatic'. Very few are reported to originate with trauma.

In the past several different coding solutions have been offered. In order to rationalize the coding of RSH, CCRG have decided that:

- a) The terms 'spontaneous RSH', 'non-traumatic RSH' and 'RSH' (i.e. RSH unspecified) should each be recorded by using the following two codes together:

M62.88 Other specified disorders of muscle (5th digit 8 trunk)

R58.X Haemorrhage, not elsewhere classified

- b) RSH stated to be due to trauma should be coded following the index trail above to

S30.1 Contusion of abdominal wall

with the appropriate external cause code.

SCOTTISH CLINICAL CODING STANDARDS – OPCS4

Application of patches (Fentanyl, Qutenza)

Application of Fentanyl or Qutenza patches should be coded to:

X39.5 Transdermal administration of therapeutic substance.

Please note that this standard supercedes previous guidance re application of Fentanyl patches in Coding Guidelines No. 7 November 2000.

GENERAL INFORMATION

Scottish Morbidity Record (SMR) and Hospital Standardised Mortality Ratios (HSMR)

SMR and HSMR are similar acronyms which could suggest they are related but **they are not**.

HSMRs are derived from SMR information, including clinical codes. To ensure that HSMRs are as accurate and transparent as possible it is important that coders adhere to the rules of coding, and Scottish Clinical Coding Standards (previously Coding Guidelines).

On SMRs 'Cause of Death' should only be recorded as Main Condition if this conforms with the rules of coding. 'Cause of Death' should not automatically be coded as Main Condition as the main condition being treated is frequently NOT the same as 'Cause of Death' which is recorded on the Death Certificate and coded by National Records of Scotland. Cause of Death may of course be a comorbidity in the patient's episode, and could be recorded as such. See Coding Guidelines No.21 November 2007 for further guidance on comorbidities.

Please note: the main condition is the condition, diagnosed at the end of the episode of health care, primarily responsible for the patient's need for treatment or investigation.

If coders are at all in doubt they should contact the Terminology Services Helpdesk.

SMR04 Discharge Diagnoses

In the past, both SMR04 coding training and the Data Dictionary have stated that only four discharge diagnoses may be submitted on SMR04. In fact many systems submitting SMR04 can submit six discharge diagnoses.

This is to alert any SMR04 coders who may not be aware of this to the fact that, if their local system allows, up to six SMR04 discharge diagnoses may be submitted. The Data Dictionary has been altered accordingly.

<http://www.datadictionaryadmin.scot.nhs.uk/SMR-Datasets/SMR04-Mental-Health-Inpatient-and-Day-Case/Diagnostic-Section/>

PLEASE NOTE THAT ALL NEW STANDARDS IN THIS EDITION APPLY TO ALL DISCHARGES ON AND AFTER 1ST OCTOBER 2013.

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

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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