Q: Can you code G46.0 with the main diagnosis from I63.x segment, because in the I66 it sazs that the I63.- is excluded when causing cerebral infraction....specifically with I63.4 as main diagnosis

G46.- can only be coded when »cerebral artery syndrome is documented by the treating clinician.

If the infarct is caused by occlusion/stenosis of cerebral artery, then i63.- must be used

There is no exclusion note for i63.- that i46.0 cannot be used with i63.-

Q: f the patients was admitted for acute kidney injury that was the result of infection, which of these is the principal diagnosis?

The reason for admission is the acute kidney injury (ACS 0001), followed by the infection as the additional diagnosis

Can you code G44.8 if a patient is firstly recieved for headache and the during the hospital stay and test it is discovered that the reason for this is I60.8, or when can you code G44.8

*G44.8 Other specified headache syndromes* is only coded if headache syndrome is documeted by the treating clinician

In this case the underlying cause of the headach is stated to be the subarachnoid haemorrhage, so the ONLY code required here is i60.8

The headache is a symptom of the Subarachnoid haemorrhag so it is not coded

See ACS 0001, subheading CODES FOR SYUMPTOMS, SIGNS AND ILL-DEFINIED CONDITIONS

»Codes for symptoms, signs and ill-defined conditions from Chapter 18 *Symptoms signs and abnormal clinical and laboratory findings* are not to be used as principal diagnosis when a related definitive diagnosis has been established”

can you show us coding advice for use of D63\* ?

**NOTE**: This code can only be found in the index under the lead term of the conditions lsited in Coding Rule TN184.

Coding Rule TN184

**Anaemia in chronic diseases**

**Q:**

When can code D63\* *Anaemia in chronic diseases classified elsewhere* be assigned?

**A:**

This code can only be assigned for the following indexed conditions:

**Anaemia**

- brickmaker's B76.9+ D63\*

- Diphyllobothrium (Dibothriocephalus) B70.0+ D63\*

- due to

- - myxoedema E03.9+ D63\*

- Egyptian B76.9+ D63\*

- hookworm B76.9+ D63\*

- malarial *(see also Malaria)* B54+ D63\*

- marsh *(see also Malaria)* B54+ D63\*

- miner's B76.9+ D63\*

- paludal *(see also Malaria)* B54+ D63\*

- syphilitic (acquired) (late) A52.7+ D63\*

- tropical B76.9+ D63\*

- tuberculous A18.8+ D63\*

**Chlorosis**

- Egyptian B76.9+ D63\*

 - miner's B76.9+ D63\*

**Syphilis, syphilitic** (acquired)

- anaemia (late) A52.7+ D63\*

**Tuberculosis, tubercular, tuberculous** (caseous) (degeneration) (gangrene) (necrosis)

- anaemia A18.8+ D63\*

Follow coding guidelines relating to aetiology and manifestation (dagger and asterisk) convention in ACS 0001 *Principal diagnosis.*

This advice has a minor modification to correspond with an update in a subsequent edition of ICD-10-AM/ACHI/ACS.

***(Coding Q&A, October 2010)***

How do you code a case when a bronchoscopy is done due to lung allograft failure, but biopsy does not show acute rejection?

If acute rejection is not found, then code the symptoms that were the reason for doing the bronchoscopiy

Does it make sense to code for MRSA carriage (patients requires additional contact precautions) and how do we code it?

Carrier status is coded using code Z22.-. A code for MRSA cannot be used in this situation.

Assign code Z29.0 *Isolation* if the patient was isolated for the MRSA carrier status.

How do you code if a patient is admitted to a day hospital for thoracocentesis, but is ultimately not done (but ultrasound and chest x-ray were done)

Assign as the Principal diagnosis the reason for the admission for thoracocentesis

If the procedure was cancelled code Z53.- as an additional diagnosis, plus the reason for the cancellation if applicable

ADDITIONAL DIAGNOSIS QUESTION: On the one hand you say that the criteria for additional diagnosis coding among others is monitoring and extra work, yet if it is supposedly routine it does not count. For example surgical patients with diabetes during hospitalisation ? They have (routine) additional blood level sugar tests done and and additional medical paper for follow-up those levels. Sometimes the therapy is changed, sometimes not. This clearly cheks the two criteria you told us : it uses EXTRA WORK (for nurses and doctors to check it) and is MONITORED in comparison to patients without diabetes ? I assume that your answer is that if the therapy is routinely administered and not changed it should not be coded, but it is hard to understand for me why should this "extra work not be billed" ? The same goes for ulcer care (requires extra work, doctor needs to chek it). Thank you. Aleksander Gonter (UMC Ljubljana)

The code for diabetes is always assigned (ACS 0401, rule 1« **DM and IH should always be coded when documented.** The DRG may change where diabetes is included in the additional diagnoses.

If the ulcer is checked by the doctor, and a Care Plan documented (continue dressing, etc) then the ulcer should be coded.

Hello, which code is assigned if there is an incident during sample processing and consequent tissue destruction.
Therefore, no pathological definition was possible. Thank you

 Then assign the code for the surgeon's diagnosis, or the reason for the biopsy.

If a patients is on hemodialysis and requires prolonged hospitalization - do we code N18.5 for end stage kidney disease or Z99.2 for dialysis dependency or both?

## Coding CKD and dialysis

See ACS 1438, subheading Kidney Replacement Therapy, Classification point 4:

“For patients dependent on haemodialysis or peritoneal dialysis for end-stage kidney disease, but not receiving dialysis treatment during the current admission, assign Z99.2 *Dependence on kidney dialysis* with N18.3 *Chronic kidney disease, stage 3* or higher, as indicated by an eGFR/GFR level where CKD meets the criteria for code assignment (see ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*).”

Multi-day stay admissions

IF CKD and NO dialysis during this admission

AND IF CKD meets ACS 0002

THEN assign code Z99.2 *Dependence on kidney dialysis* and N18.- *Chronic kidney disease*

IF CKD and NO dialysis during this admission

AND IF CKD **does not** meet meets ACS 0002

THEN assign code Z99.2 *Dependence on kidney dialysis* and U87.1 Supplementary code for *Chronic kidney disease*

IF CKD and dialysis during this admission

THEN code N18.- *Chronic kidney disease* and the ACHI dialysis code

(Z99.2 is not assigned where an ACHI dialysis code is assigned).

Were there any amendmends or recomme3ndations for patients with sepsis. v11 grouper gives very low costweights.

This is beyond my expertise

If a patients has a chronic kidney disease that causes changed treatment for example in fracture. Does  kidney disease count as additional diagnosis

Only if investigated by the treating clinician – in other words when it meets the requirements of ACS 0002 *Additional Diagnosis*

how do you code if a patient with a known PAH (I27.2) is admitted for a right heart catheterization for evaluation of therapy? Same diagnosis?

Yes, same diagnosis

If a patient was admitted with urinary tract infection and they have a urinary catheter inserted (prior to admission), do we always code as T83.5 - urinary catheter associated infection + site of infection or just T83.5?

NO!!!

The UTI must be documented by the treating doctor as »due to the catheter« before T83.5 can be assigned. The catheter is not always the cause of the UTI.

what is the correct coding for a patient admituted for overdose of a frug, also chronic alcohol adiction. Is F correct principal diagnosis

Admission for an **overdose** is coded from the Table of Drugs

Admission for alcohol addiction is coded as F10.2

Please, note that there are Slovenian additions to coding standards (in Annex B and also at particular coding standard - in translated document)

Noted.

Can we code T79.2 as an additional diagnosis if the patient receives concentrated erythrocytes due to bleeding as a result of injury?

No, - use the code for anaemia due to blood loss if documetned by the treating clinician.

is this correct coding Admission: a 63-year-old female patient was admitted to the Department of Gynaecology for the planned insertion of a JJ splenectomy stent via a nephrostomy. She has a recurrence of Ca ovaries, surgery, CT. She has had a recurrence since 2022 and has a JJ splint inserted in the left ureter, which is in situ. She has a right-sided nephrostomy.

Hospitalisation course: After adequate pre-preparation, the patient underwent an interventional radiological procedure to insert a JJ splint with a diameter of 8 FR, and to remove the PNS.

 Discharge dg:
C56 Malignant neoplasm of ovary (ovarian), recurrence 🡨 This is not the Principal diagnosis
Z08.7 Follow-up after combination treatment for malignant neoplasm. 🡨 this is incorrect, it is not a follow-up case see ACS 0052

The reason for admission is the insertion of the stent Z46.6. The cancer is not coded unless also treated during this admission as the cancer does not meet the requirements of ACS 0236

1. How do we code Paget's disease of the vulva (ext. geniatalia)?

**Paget's disease**

- Malignant

- - specified site NEC – See Neoplasm/skin/malignant 🡨 then go to the Neoplasm Table

2. Can we code H55 as an additional diagnosis for caesarean section?

H55 in an obstetric patient must be coded as O99.32 THEN H55

See ACS 1544

3. In postpartum anaemia where there is significant blood loss, can we code D62 in addition to O99.03?

Yes, see the note for all codes in O99.0 in the Tabular List »*Code also specific type of anaemia if known.”*

BUT note that D62 can ONLY be assigned where the treating doctor states ***acute posthaemorrhagic anaemia***

A more appropriate code would be D50.0 anaemia due to blood loss

If a pacient has rotavirus infection A080 and is admited because of dehitration and gets i.v. infusion. Can we code E86

Yes, where dehydration is documented, and IVF is given then code E86 is assigned

NOTE: that dehydration cannot be coded with only documentation of IVF

if there is an acute deterioration of a known chronic kidney failure, do you code N17 or N18?

Acute deterioration of chronic kidney disease is coded as N17.9 and N18.- using ACS 0001 subheading »Acute on Chronic Conditions

An abrasion of the uterus was performed, histology shows that it is a carcinoma.
How to encrypt?

Assign the code for the carcinoma of the uterus, and NOT the abrasion.

A patient was addmited to the hospital due to fever and infection. He has implated ICD. During the hospitalisation the blood test showed the S. Auerus . The doctor made a conclusion that the reason of infection/sepsis was the implanted ICD eletrode. What is the main diagnosis in that case, sepsis A410 ot the code T8271?

T82.71 followed by A410

See the note under T82.7- »*Use additional code for the specific condition, if known (eg cellulitis, sepsis).*

If the patients is admitted due to rhabdomyolysis and the conclusion is that it is an adverse effect of statin therapy (in therapeutic doses) - how do we code statin therapy adverse effect (if at all)?

See ACS 1902 Adverse Effects

Assign first the code for rhabdomyolysis (the non-traumatic code)

Then assign the code from the last column (adverse effect in therapeutic use) of the Table of Drugs for Anticholesterolemic drug or for the chemical name of the statin given.

Patient has a known MDS mielodispl. and needs transfusion. whats the principla diagnosis

The PDx is MDS as per ACS 0044 Pharmacotherapy (regardless whether a day-stay or multi-stay admission)

ad h55- high dioptrdy as indication cesaean secxtion

H55 in an obstetric patient must be coded as O99.32 THEN H55

See ACS 1544

If a patient is admited for procedure due to an intervertebral disc defect, is the correct coding M51.1 + G55.1\* (rule +\*)?

For this case M51.1 + G55.1\* is incorrect as there is no statement of herniation or displacement of the disc

The correct code is **Disease** – intervertebral disc M51.9 or the code for the site of the disc defect.

M51.1 + G55.1\* can only be used for documetnation of neuritis, radiculitis or radiculopathy with a disc disease

+\* is no logner obligatory. patient is admitted one day for transfusion. and he is oncolog patient. what is principal diagnosis. D639 or C, euther? NOT D63

What about E94.2? 🡨 this code does not exist

I assume that the patient was admitted for transfusion of blood or packed blood cells so for this patient the Principal Diagnosis is a code for anaemia (not D63)

Hello. We had a case where we had two young patient who had a confirmed CDH1 mutation - hereditary diffuse gastric cancer disease. We did a propyhlactic  gastrectomy (big procedure). Histologically there was no cancer yet confirmed. In the end we coded as the main diagnosis Z12.9 and got a very low score for the insurance bill. Is this a correct coding?

I would assign a code for the chromosomal abnormality ?Q99.-

[7.5 10:54] Neznani uporabnik

So it appears e94.2 is adverse effect of antilipemic drugs **No, Code Y52.6**

[7.5 10:54] Neznani uporabnik

A propos my previous question

[7.5 10:55] Neznani uporabnik

Perhaps it’s a different clasification, sorry

[7.5 10:55] Neznani uporabnik

Patient is admited for lumbal punction, suspition of multiple sclerosis. MS not confirmed. Which is principal diagnosis?

The symptoms that caused the suspicion of MS

[7.5 10:55] Neznani uporabnik

are blood products included in DRG payment? any copayments in Australia

how do you code for patient admitted for closing of 2wound after VAC treatment, the reason for VAC was infection around sternoclavicular joint.

Z48.0 Attnetion to surgical dressings and sutures 🡨 The treatment is for the closure of the wound, no longer for the sternoclavicular joint infection. Note that the DRG leader will probably be the procedure.

Would it be appropriate (for anemia associated with neoplastic disease) to code for D64.8 (if they need transfusion, I suppose we should code anemia??)

No, not D64.8 because it is not a specific type of anaemia, just code D64.9

if we admit a patient for epidural  due to spinal stenosis  and a patient has a signs of radiculopaty  and stenosis claudication  can we use M48.0 and G55.1  or just M48.0

I suggest coding the stenosis M48.0 and also Radiculopathy M54.18

If the lung lession is confirmed to be a metastasis (C78.0) and the primary cancer was already operated (i.e. colon cancer), we still add C18 as a secondary diagosis?

Yes, see ACS 0236

If a patient has diabetes with diabetic kidney disease and is admitted for acute kidney disease, is the order of diagnoses 17.8 for AKI, then N18.3 for CKD and E11.71 as cause of kidney disease?

It is not an »other« type of acute kidney disease so assign code N17.9 E11.29 then N18.3 E11.22, Code E11.71 is only assigned for a combination of kidney, ophthalmic or neurological complications.

**ACS 0401**

**CLASSIFICATION**

E1-.71 *\*Diabetes mellitus with multiple microvascular and other specified nonvascular complications* should be assigned when the individual has **conditions classifiable to two or more of the following five categories:**

1. Kidney complications (E1-.2-)

2. Ophthalmic complications (E1-.3-)

3. Neurological complications (E1-.4-)

4. Diabetic cardiomyopathy (E1-.53)

5. Skin or subcutaneous tissue complications (E1-.62)

So, I suppose then E11.71 can only be used if they also have diabetic retinopathy in addition?

Correct, or neuropathy

Can we use code E11.49 in diabetic patiens with  ischemic stroke

NO. There is no listing in the index for **Diabetes, -** with, - - ischaemic stroke.

It is not permissable to assign a code that is not listed in the index pathway.