CYPRUS
CODING GUIDELINES

General and Special
Coding Guidelines
for the coding of
diseases and procedures

V1.01

Health Insurance Organisation (HIO) in cooperation with the
Institute for the Hospital Financing System (InEK GmbH)

PREFACE

General and Special Coding Guidelines for diseases (ICD-10-CY) and procedures (CMP-CY)

In 2001, the House of Representatives enacted the National Health Insurance System (NHIS) Law. The Law established the Health Insurance Organisation (HIO) whose objective is the implementation of the NHIS. As regards the reimbursement of inpatient healthcare services, the Law stipulates that the HIO may use methods such as fee for service, or DRGs (Diagnosis Related Groups) and others. The HIO has decided to adopt a DRG system.

A DRG system classifies inpatient cases into specific groups (500-1200 depending on the system) based primarily on their convergence regarding clinical history (diagnoses), consumption/usage of hospital resources (procedures) and patient demographics (age, sex etc). For each inpatient case/patient, the above data are entered into a special software program (DRG grouper) which processes them and assigns each case to the proper DRG. Each DRG has a relative cost weight assigned to it, which provides the basis for compensating inpatient healthcare providers.

Diagnoses and procedures need to be entered into the DRG Grouper in code form using special catalogues. As regards diagnoses and procedures, the following two catalogues which include the relevant description and codes, will be used in Cyprus.

Diagnoses: ICD-10-CY, V1.0 – Based on the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (i.e. ICD-10)

Procedures: CMP-CY, V1.0 (Classification of Medical Procedures for Cyprus) - Based on the International Classification of Diseases, 9th Revision, Clinical Modification (i.e. ICD-9 CM)

To help ensure correct coding for each inpatient case and thus the assignment of each case to the proper DRG, the HIO in cooperation with the German Institute for the Hospital Remuneration System (InEK GmbH) have developed a set of guidelines/rules whose purpose is to explain to all interested parties how to perform proper medical coding using the above catalogues.

These coding guidelines will have to be followed by coders in identifying the diagnoses and procedures that are to be reported for each hospital case and which will be used in order to select the appropriate codes from the above catalogues. As diagnosis and procedure codes directly affect the DRG assignment, which in turn, affects provider compensation, correct coding is of critical importance. Therefore, adherence to the coding guidelines as well as consistent, complete documentation in the medical record cannot be overemphasised. Without such documentation, accurate coding cannot be achieved and consequently, the case cannot be assigned to the proper DRG and the correct compensation cannot be paid to inpatient healthcare providers.

Οδηγός χρήσης κωδικοποίησης διαγνώσεων (ICD-10 CY) και κλινικών διεργασιών (CMP-CY)

Το 2001, η Βουλή των Αντιπροσώπων ψήφισε το Νόμο που προβλέπει για την εισαγωγή του Γενικού Συστήματος Υγείας (ΓεΣΥ). Με βάση το Νόμο αυτό, ιδρύθηκε ο Οργανισμός Ασφάλισης Υγείας (ΟΑΥ) του οποίου σκοπός είναι η εφαρμογή του ΓεΣΥ. Όσον αφορά στην αποζημίωση των υπηρεσιών ενδονοσοκομειακής περίθαλψης, ο Νόμος ορίζει όπως ο ΟΑΥ δύναται να χρησιμοποιεί διάφορες μεθόδους, όπως αποζημίωση κατά ιατρική πράξη, ή αποζημίωση κατά DRG (Ομάδες Συγγενών Διαγνώσεων) ή και άλλες μεθόδους. Ο ΟΑΥ αποφάσισε όπως υιοθετήσει το σύστημα των DRGs.

Το σύστημα των DRGs ταξινομεί τα περιστατικά ενδονοσοκομειακής περίθαλψης σε συγκεκριμένες ομάδες (500-1200 ανάλογα με το σύστημα) με βάση κυρίως τη σύγκλιση τους σχετικά με την κλινική εικόνα (διαγνώσεις), χρήση νοσοκομειακών πόρων (κλινικές διεργασίες) και δημογραφικά στοιχεία του ασθενή (ηλικία, φύλο κ.α.). Για κάθε ενδονοσοκομειακό περιστατικό/ασθενή, τα πιο πάνω στοιχεία καταχωρούνται σε ειδικό λογισμικό πρόγραμμα (DRG grouper) το οποίο αφού τα επεξεργαστεί, εντάσσει το κάθε περιστατικό στο κατάλληλο DRG. Σε κάθε DRG αντιστοιχεί μια σχετική βαρύτητα κόστους (relative cost weight) η οποία αποτελεί τη βάση για αποζημίωση των παροχέων υπηρεσιών ενδονοσοκομειακής περίθαλψης.

Για την ένταξη των διαφόρων περιστατικών στο κατάλληλο DRG, οι διαγνώσεις και κλινικές διεργασίες πρέπει να καταχωρούνται στο λογισμικό Grouper, υπό μορφή κωδικών κάνοντας χρήση ειδικών καταλόγων. Οι δύο κατάλογοι που συμπεριλαμβάνουν τους κωδικούς αυτούς και οι οποίοι θα χρησιμοποιούνται στην Κύπρο είναι:

Διαγνώσεις: ICD-10-CY, Έκδοση 2010 – Βασισμένος στο International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10)

Κλινικές Διεργασίες: CMP-CY (Ταξινόμηση των Κλινικών Διεργασιών της Κύπρου) – Βασισμένος στο International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 CM)

Για τη διασφάλιση της ορθής κωδικοποίησης που αφορά στα περιστατικά ενδονοσοκομειακής περίθαλψης και ως επακόλουθο, την ταξινόμηση τους στα κατάλληλα DRGs, ο ΟΑΥ σε συνεργασία με τον Γερμανικό Οργανισμό InEK GmbH ετοίμασαν οδηγό κωδικοποίησης ο οποίος έχει σαν στόχο την παροχή βοήθειας και διευκρινήσεων στους κωδικοποιητές για την εκτέλεση ορθής κωδικοποίησης με βάση τους πιο πάνω καταλόγους.

Ο οδηγός κωδικοποίησης πρέπει να ακολουθείται κατά γράμμα από τους κωδικοποιητές, ώστε αυτοί να εντοπίζουν τους κατάλληλους κωδικούς που αφορούν τόσο στις διαγνώσεις (diagnoses) όσο και στις κλινικές διεργασίες (procedures) που διενεργήθηκαν για το κάθε περιστατικό. Οι κωδικοί αυτοί επηρεάζουν άμεσα την ένταξη του κάθε περιστατικού στο κατάλληλο DRG και ως εκ τούτου, επηρεάζουν και την αποζημίωση του κάθε παροχέα. Συνεπώς, η πλήρης συμμόρφωση με τον οδηγό κωδικοποίησης αλλά και η ολοκληρωμένη ενημέρωση του ιατρικού φακέλου του κάθε ασθενή με όλα τα στοιχεία που χρειάζεται ένας κωδικοποιητής είναι ύψιστης σημασίας. Φάκελοι που δεν περιέχουν όλα τα απαραίτητα στοιχεία θα οδηγούν σε λανθασμένη κωδικοποίηση και ως επακόλουθο, σε ένταξη του περιστατικού σε λανθασμένο DRG και έτσι σε λανθασμένη αποζημίωση προς τους παροχείς.

CONTENTS

LIST OF ABBREVIATIONS

Abbreviation	Name/description
AIDS	Acquired Immune(o) Deficiency Syndrome
ASB	Assisted Spontaneous Breathing
AV	Arteriovenous
Ca	Carcinoma
CCG	Cyprus Coding Guideline
CMP-CY	Cyprus Classification of Medical Procedures
CML	Chronic Myeloid Leukaemia
CPAP	Continuous Positive Airway Pressure
DRG	Diagnosis Related Group
ECG	Electrocardiogram
EEG	Electroencephalogram
e.g.	Exempli gratia, (for example)
EP	Effort Points
etc.	et cetera (and so on)
Excl.	Exclusive
GI	Gastrointestinal
HIV	Human Immune Deficiency Virus
ICD	International Classification of Diseases
ICD-10-CY	International Statistical Classification of Diseasese and related health problems, 10th Revision, Cyprus Modification
ICU	Intensive Care Unit
i.e.	id est (That is)
InEK	Institute for the Hospital Financing System (Institut für das Entgeltsystem im Krankenhaus GmbH)
Incl.	Including
MALT	Mucosa Associated Lymphoid Tissue
MICU	Mobile Intensive Care Unit
N.B.	Nota Bene (please note)
PSV	Pressure Support Ventilation
s.	See
s.a.	See also
SAPS	Simplified Acute Physiology Score
SIMV	Synchronized Intermittent Mandatory Ventilation
TISS	Therapeutic Intervention Scoring System
WHO	World Health Organisation

EDITORIAL NOTES

I. General information

The Cyprus Coding Guidelines (CCG) are characterised by the following rules:

1. All coding guidelines are assigned a permanent three-digit code, e.g. D01.
2. The **General Coding Guidelines for Diseases** start with a "D" followed by a two-digit number.
3. The **General Coding Guidelines for Procedures** start with a "P", followed by a two-digit number.
4. The **Special Coding Guidelines** start with an "S", followed by a two-digit number.

Examples and/or listings with ICD-10-CY or CMP-CY codes are specified in many coding guidelines. These examples or listings do however not represent the final listing/differentiation of all applicable codes. To find the exact codes, please refer to the cross references with inclusions, exclusions and notes in the respective classifications.

II. Codes

The Cyprus Coding Guidelines refer to codes from the ICD-10-CY and the CMP-CY. These codes are listed **in various ways**.

The coding guidelines comprise coding instructions that refer to individual (terminal) codes and also to hierarchically superordinated codes.

In some instances, it is expressly stated in the coding guidelines that a category comprises subcategories/subclassifications, which are described in more detail. Elsewhere there is mention of subcategories with phrasing such as "should be coded/assigned a code from category ….". In these cases, the respective coding instructions for all terminal codes classified under the specified category apply.

Always select the appropriate code for a specific medical condition/disease and/or procedure in the highest degree of differentiation (up to the last digit in the code) for medical documentation.

The following tables illustrate typical code examples.

Display of codes in the Cyprus Coding Guidelines

1. ICD-10-CY

Code example	Text (*italic*)	The coding guideline refers to
E10–E14	*Diabetes mellitus*	the group with all subcategories.
E10–E14, 4th digit ".5"	*Diabetes mellitus with peripheral circulatory complications*	the 4th digit of a group (here: 4th digit ".5").
E11.–	*Non-insulin-dependent diabetes mellitus*	the three-digit code with all classified codes thereunder.
I20.0	*Unstable angina*	exactly this code (terminal code).

2. CMP-CY

Code example	Text (*italic*)	The coding guideline refers to
42	*Operations on esophagus*	the two-digit code with all classified terminal codes thereunder (here: three-digit code 42.0 to 42.9 with all fourth digits).
42.0	*Esophagotomy*	the three-digit code and all classified terminal fourth-digit codes thereunder.
42.01	*Incision of esophageal web*	this code exactly (terminal code).

III. Case studies

The Cyprus coding guidelines comprise coding instructions and relevant case studies for your information. The examples include a clinical case description followed by the appropriate codes and the respective classification texts (ICD-10-CY or CMP-CY) printed in italics.

While the ICD texts carried over from the classification are generally true to the original, the texts in the CMP-CY codes have partially been revised to avoid conveying redundant information and to shorten very long and unclear passages. They do, however, convey the full information content of the respective CMP-CY code.

Many examples show the complete coding of an inpatient case with all diagnoses and procedure codes.

In other cases, codes are only listed in connection with the respective coding guideline. Thus, diagnosis codes may not have been included in examples illustrating the coding of certain procedures, or procedures are missing in examples demonstrating the assignment of diagnosis codes.

In examples where ICD codes were assigned for “not otherwise specified” diagnoses, the diagnoses stated in the text example have been correctly coded in accordance with ICD-10-CY guidelines. With the exception of example 2 in CCG P03 *Multiple/bilateral procedures* (page 14), no reference was made to page locality. ICD codes and/or CMP-CY codes were provided without additional identification, i.e. R=right; L=left, B=bilateral.

GENERAL CODING GUIDELINES

GENERAL CODING GUIDELINES FOR DISEASES

These coding guidelines pertain to the following:

ICD-10-CY, V1.0

D01 General Coding Guidelines

The responsibility for the listing of diagnoses and procedures rests with the treating physician. Even though findings are crucial points in the coding process, there are some diseases which are not always confirmed by findings. Morbus Crohn is, for example, not always confirmed by biopsy.

The treating physician is responsible for

- the confirmation of diagnoses documented in the patient's file without supporting evidence,

  and

- clarifying discrepancies between examination findings and clinical documentation.

D02 Principal diagnosis

The principal diagnosis is defined as

"the condition/diagnosis established after study to be chiefly responsible for occasioning the admission of the patient to the hospital."

The term "after study" refers to the assessment of findings at the end of hospitalisation to determine the disease which is chiefly responsible for occasioning the patient's episode of care in hospital. The evaluated findings may contain information derived from the medical and nursing history, a psychiatric examination, consultations with specialists, a physical examination, diagnostic tests or procedures, surgical interventions and pathological or radiological examinations. For the coding process, findings relevant for invoicing following the patient's discharge will be referred to.

The principal diagnosis after study does not have to correspond to the diagnosis at the time of admission.

Example 1

A patient suffering from severe chest pain in the morning was taken to hospital via MICU following an examination by the emergency physician, and examined in the Accident & Emergency Unit. The patient was subsequently admitted to the coronary care unit with suspected myocardial infarction. Myocardial infarction was confirmed during the course of further diagnostic evaluation.

The following diagnoses were made during the patient's hospitalisation up to the time of discharge:

- Diabetes mellitus
- Coronary sclerosis
- Myocardial infarction

The circumstances of inpatient admission always govern the selection of principal diagnosis. In this case, the principal diagnosis is the myocardial infarction, since it was chiefly responsible for occasioning the admission of the patient to hospital.

In determining the principal diagnosis, the present coding guidelines take precedence over all other guidelines. Coding instructions using the ICD-10 indices must be adhered to.

Assignment of underlying disease as principal diagnosis

The underlying disease should be coded as principal diagnosis if a patient presents with a symptom and the underlying disease has already been documented and is being treated at the time of the patient's hospitalisation, or is diagnosed during hospitalisation. Please refer to CCG D03 *Secondary diagnoses* for the coding of symptoms as secondary diagnosis.

Example 2

A patient is admitted with acute pain in the right lower abdomen, fever and feeling unwell. Acute appendicitis is diagnosed and the patient undergoes an appendectomy.

Principal diagnosis:	Acute appendicitis
Secondary diagnosis:	None

Assignment of a symptom as principal diagnosis

If a patient presents with a symptom, and the underlying disease is known at the time of the patient's admission but only the symptom is being treated, the symptom should be coded as principal diagnosis and the underlying disease as secondary diagnosis.

Example 3

A patient with ascites in connection with documented cirrhosis of the liver is admitted to hospital. **Only** the ascites is being treating by means of a puncture.

Principal diagnosis:	Ascites
Secondary diagnosis:	Cirrhosis of the liver

N.B.: For further information on the selection of the principal diagnosis in special cases, please refer to the following general rules and regulations in the special chapters. Special coding guidelines exist for the principal diagnosis selection, particularly in the case of patients admitted for dialysis (s.a. CCG S13 *Dialysis* (page 34)).

Codes for symptoms, findings and ambiguously described medical conditions

Codes for symptoms, findings and ambiguously described medical conditions from Chapter XVIII *Symptoms, signs and abnormal clinical and laboratory findings not classified elsewhere* should not be assigned as principal diagnosis once a definite diagnosis explaining the symptoms, etc., is available.

The comments at the beginning of Chapter XVIII in the ICD-10-WHO are designed to assist with the decision when codes from Categories R00-R99 have to be assigned nevertheless.

Two or more diagnoses all conforming to the definition of principal diagnosis

In the event that two or more diagnoses comply with the principal diagnosis criteria regarding admission, examination findings and/or performed treatment, and neither the ICD-10 data set nor the coding guidelines provide any reference/guidance, the treating physician will have to decide which diagnosis most closely corresponds to the definition of principal diagnosis. The treating

physician should in this case only select the diagnosis which, in terms of the examination and/or the treatment involved, caused the greater utilisation of hospital resources, irrespective of whether these diseases are related or not.

Codes from Z03.0 to Z03.9
Medical observation and evaluation for suspected diseases and conditions

Codes from Z03.0 to Z03.9 will **exclusively** be assigned as **principal diagnosis** for classifying the patient's health status **if** there is evidence of an abnormal condition due to an accident or another event that subsequently led to these typical health problems, and the suspected disease is **not** confirmed and treatment is therefore **not** required.

Example 4

A mother finds her child with an empty box of tablets. The whereabouts of the tablets is unknown. Although the child is not exhibiting any symptoms, he/she is admitted for observation for a suspected toxic effect from the ingested medication. During the further course of the child's hospitalisation, no evidence of a toxic effect from ingested tablets comes to the fore.

Principal diagnosis:	Z03.6	*Observation for suspected toxic effect from ingested substance*
Secondary diagnosis:		None

If a more specific code is available for principal diagnosis, it shall have precedence over a code from Category Z03.– *Medical observation and evaluation for suspected diseases and conditions*. In the event that a symptom can be linked to the suspected diagnosis, the symptom code rather than a code from Category Z03.– *Medical observation and evaluation for suspected diseases and conditions* (s.a. CCG D06 *Suspected diagnoses* (page 10)) shall be assigned as principal diagnosis.

If two or several findings/symptoms comply with the principal diagnosis criteria during the observation of a suspected case, the treating physician should select the diagnosis, which caused the greater utilisation of hospital resources.

Postprocedural diseases and/or disorders

Please refer to the following categories for the coding of postprocedural diseases and/or disorders:

Table 1:

E89.– *Postprocedural endocrine and metabolic disorders, not elsewhere classified*
G97.– *Postprocedural disorders of nervous system, not elsewhere classified*
H59.– *Postprocedural disorders of eye and adnexa, not elsewhere classified*
H95.– *Postprocedural disorders of ear and mastoid process, not elsewhere classified*
I97.– *Postprocedural disorders of circulatory system, not elsewhere classified*
J95.– *Postprocedural respiratory disorders, not elsewhere classified*
K91.– *Postprocedural disorders of digestive system, not elsewhere classified*
M96.– *Postprocedural musculoskeletal disorders, not elsewhere classified*
N99.– *Postprocedural disorders of genitourinary system, not elsewhere classified*

These codes should only be assigned as principal diagnosis if a more specific code for the disease and/or disorder does not exist, or if the assignment of a more specific code is excluded according to ICD-10. The same applies to categories T80–T88 *Complications of surgical and medical care, not*

elsewhere classified. The codes in Table 1 should take precedence over codes from T80–T88, if the T80-T88 codes do not provide a more specific description of the disease and/or disorder.

Example 5

A patient is admitted owing to hypothyroidism following thyroidectomy a year previously.

Principal diagnosis: E89.0 *Postprocedural hypothyroidism*

Example 6

A pacemaker carrier is hospitalised owing to electrode dislocation.

Principal diagnosis T82.1 *Mechanical complication of cardiac electronic device*

N.B.: I97.8 *Other postprocedural disorders of circulatory system, not elsewhere classified* is not to be assigned as principal diagnosis since code T82.1 *Mechanical complication of cardiac electronic device* (and addenda) specifically describes this type of disorder.

Example 7

A patient is readmitted with deep vein thrombosis following the treatment of a calcaneal fracture.

Principal diagnosis: I80.2 *Phlebitis and thrombophlebitis of other deep vessels of lower extremities*

N.B.: I97.8 *Other postprocedural disorders of circulatory system, not elsewhere classified* must not be assigned as principal diagnosis since code I80.2 *Phlebitis and thrombophlebitis of other deep vessels of lower extremities* specifically describes the type of circulatory complication.

D03 Secondary diagnoses

Secondary diagnosis is defined as

"a concurrent condition or symptom that coexists with the principal diagnosis, or develops during the patient's hospital stay."

For coding purposes, secondary diagnoses must be interpreted as conditions which influence patient management in such a way that one of the following factors becomes necessary:

- therapeutic measures
- diagnostic measures
- increased care and supervision requirements

In cases where one of these factors applies to several diagnoses, all respective diagnoses can be coded**.**

Example 1

A patient receives beta blocker therapy for the treatment of the secondary diagnoses coronary heart disease, arterial hypertension and cardiac insufficiency.

Secondary diagnoses:	Coronary heart disease
	Arterial hypertension
	Cardiac insufficiency

Conditions which are, for example, documented by the anaesthesist during the preoperative assessment are only coded if they conform to the above criteria. Insofar as a concomitant disease influences the standard treatment in connection with a special procedure, this disease will be coded as secondary diagnosis.

Diagnoses stated in the case history which have no influence on patient management according to the above definition, e.g. resolved pneumonia six months previously or a resolved ulcer, are not coded.

Example 2

A patient is hospitalised for the treatment of chronic myeloid leucaemia (CML). Her past medical history includes a knee operation owing to an injury to the outer meniscus 10 years previously. The patient was symptom-free thereafter. She currently receives drug therapy for the treatment of documented coronary heart disease. The sonography of the abdominal lymphnodes showed an already documented uterine myoma which does not require any further diagnostic measures or treatment. During hospitalisation, the patient suffered from depressive reactions and was treated with antidepressants. As a result of persistent lumbalgia, the patient is currently undergoing physiotherapy.

Principal diagnosis:	Chronic Myeloid Leukaemia (CML)
Secondary diagnoses:	Depressive reaction
	Lumbalgia
	Coronary heart disease

The secondary diagnoses meet the above definition (utilisation of hospital resources) and should thus be documented.

The other diagnoses (uterine myoma, status post outer meniscus surgery) do not meet this definition and will therefore not be documented for the DRG system. They are, however, of significance for medical documentation and medical communication.

Symptoms as secondary diagnosis

The coding of symptoms is governed by the coding principles specific to secondary diagnoses. It is, however, recommended not to overdocument the symptoms. The additional coding of migraine headaches, for example, is not intended. The coding of pronounced ascites in connection with cirrhosis of the liver with relief puncture is, however, required for appropriate case illustration.

Example 3

A patient is admitted for further diagnostic assessment of severe headaches. A migraine is diagnosed as the cause for the symptoms.

Principal diagnosis: Migraine

Secondary diagnosis: None

Example 4

A patient is admitted for inpatient treatment of progressive alcoholic liver cirrhosis. He exhibits pronounced ascites affecting respiration and renal function and is treated by means of relief punctures.

Principal diagnosis: Alcoholic liver cirrhosis

Secondary diagnosis: Ascites

Abnormal findings

Abnormal laboratory, X-ray, pathology and other diagnostic findings are only coded if they are clinically significant (i.e. therapeutic consequence or further diagnostic measures, not merely a follow-up of abnormal values).

Example 5

A patient is hospitalised for pneumonia. Laboratory testing yields a slightly elevated gamma GT value which is merely followed up without requiring any further diagnostic or therapeutic measures.

Principal diagnosis: Pneumonia

N.B: The elevated gamma GT value does not meet the definition of secondary diagnosis and is thus not documented for the DRG system. It is, however, of significance for the medical documentation and communication.

D04 Subsequent medical conditions and scheduled follow-up procedures

The coding of subsequent medical conditions requires assigning two codes:

- one for the actual residual/subsequent medical condition and
- a code ("result of …:") stipulating that this subsequent condition is the result of a previous medical condition.

The residual or subsequent medical condition is stated first, followed by the code ("result of …:").

Example 1

Spastic hemiplegia as the sequelae of stroke

G81.1	*Spastic hemiplegia*
I69.4	*Sequelae of stroke, not specified as haemorrhage or infarction*

If, however, a patient is admitted for tendon surgery following a tendon rupture in the fingers one or two weeks previously, it should **not** be coded as "subsequent medical condition", since the rupture is still being treated.

Treatment of acute injury/burn and scheduled follow-up procedure

The code for injuries/burns is assigned as principal diagnosis for the initial and subsequent treatment of a current injury/burn.

The original condition is coded as principal diagnosis (see examples 2 and 3), if a patient is admitted for a second/further operation following the initial procedure, providing that this operation was already scheduled at the time of the initial procedure as a follow-up procedure within the scope of the overall treatment measures.

Example 2

A patient is admitted for reverse colostomy following sigmoid diverticulitis with colostomy. Meanwhile, the sigmoid diverticulitis has cleared up.

Principal diagnosis:	Sigmoid diverticulitis
Secondary diagnosis:	Colostomy treatment

The removal of metal fragments and **further treatments** of an injury (e.g. removal of an orthopaedic nail) should be differentiated from the treatment of a follow-up condition in connection with a previous injury. In these cases, the original injury should be coded as principal diagnosis, followed by the appropriate code from Chapter XXI (e.g. Z47.0 *Follow-up care involving removal of fracture plate and other internal fixation device*) as secondary diagnosis which, together with the appropriate code for the procedure, shows the requirement for follow-up care.

Example 3

A patient presents for fracture plate removal one year after a closed distal radius fracture.

Principal diagnosis:	S52.50	*Fracture of lower end of radius: closed*
Secondary diagnosis:	Z47.0	*Follow-up care involving removal of fracture plate and other internal fixation device*
Procedure(s):	78.63	*Removal of implanted devices from bone: radius and ulna*

D05 Admission for surgical procedure, not performed

If a patient presents for a surgical procedure which is ultimately not performed for whatever reason and the patient is discharged, the following coding applies:

a) if the surgical procedure could not be performed owing to technical reasons:

Example 1

A patient is admitted for a surgical procedure to insert grommets in connection with chronic mucoid otitis media. The surgical procedure was postponed for technical reasons.

Principal diagnosis:	H65.3	*Chronic mucoid otitis media*
Secondary diagnosis:	Z53.8	*Procedure not carried out for other reasons*

b) if the surgical procedure is not performed owing to an illness or a complication which occurred after the patient was hospitalised:

Example 2

A patient with tonsillitis is admitted for a tonsillectomy. The surgical procedure had to be postponed owing to acute frontal sinusitis.

Principal diagnosis:	J35.0	*Chronic tonsillitis*
Secondary diagnoses:	Z53.0	*Procedure not carried out because of contraindication*
	J01.1	*Acute frontal sinusitis*

D06 Suspected diagnoses

Suspected diagnoses within the meaning of this coding guideline are diagnoses which have either not been confirmed or can definitely be excluded **at the end of an inpatient stay**.

The coding of suspected diagnoses varies depending on whether the patient was discharged or transferred to another hospital.

Patient discharge

The **symptom(s)** should be coded (see example 1 and CCG D02 *Principal diagnosis* (page 3)) if examinations were performed but **no** treatment in connection with the suspected diagnosis was initiated.

Example 1

A child was admitted with suspected appendicitis owing to right-sided pain in the lower abdomen. The examinations performed during the child's inpatient stay did, however, not confirm the diagnosis of appendicitis. A specific treatment for appendicitis was therefore not performed.

Principal diagnosis:	R10.3	*Pain localized to other parts of lower abdomen*

The **suspected diagnosis** should be coded, if **treatment** was initiated and the examination results were ambiguous.

Example 2

A patient presents with suspected meningitis owing to severe headaches. The examinations during the patient's hospitalisation neither confirm nor definitely exclude the diagnosis of meningitis. Specific meningitis treatment was however initiated.

Principal diagnosis	G03.9	*Meningitis, unspecified*

Patient transfer to another hospital

If a patient is transferred to another hospital with a suspected diagnosis, the hospital transferring the patient should code this event using the appropriate code for the suspected diagnosis.

The transferring hospital may only code this event based on information available at the time of the patient's transfer. Subsequent information from the hospital to which the patient was transferred may not influence the coding decision after the fact.

If, for example, a patient is transferred with suspected meningitis, and the case is coded by the transferring hospital as meningitis, the code for meningitis may not be retrospectively changed by the transferring hospital. This also applies if the other hospital, which took over the patient's treatment, sends a discharge report stating that the patient's examination results did not confirm meningitis.

GENERAL CODING GUIDELINES FOR PROCEDURES

These coding guidelines refer to the **official code of operations and procedures** (CMP-CY), **V1.0**.

P01 General coding guidelines for procedures

All significant procedures performed from the time of admission to the time of discharge and listed in the CMP-CY, must be coded. This includes diagnostic, therapeutic and care procedures.

Coding Guideline P05 *Procedures normally not coded* (page 16) specifies procedures that are not considered significant and therefore do not necessarily have to be coded.

Procedural components

A code normally illustrates a procedure with all its components (e.g. preparation, positioning the patient, anaesthesia, access, suture, etc. in a code (see example 1). Any deviations from this procedure are described in the guidelines. In the case of surgery performed on the nervous system, for example, the surgical access should generally also be coded.

The individual components of an already coded procedure are therefore not coded again separately.

The same applies to diagnostic measures related to surgical interventions if they have to be performed during the course of the same procedure and are a regular part of intervential-therapeutic procedures, and if not otherwise regulated in the CMP-CY (e.g. diagnostic arthroscopy before arthroscopic meniscectomy is not coded).

Other procedures, too, e.g. pain therapy, enteral or parenteral nutrition should only be coded if they are performed as single measures (see example 2).

Example 1

The laparotomy as surgical access is included in code

51.22 *Cholecystectomy*

An episiotomy as procedural component is included in code

72.21 *Mid forceps operation with episiotomy*

Example 2

Epidural pain therapy as single therapeutic measure (not directly linked to another procedure), e.g. during an inpatient stay with chemotherapy in connection with metastasizing cancer, should be coded separately.

99.25 *Injection or infusion of cancer chemotherapeutic substance*

03.91 *Injection of anesthetic into spinal canal for analgesia*

Independent procedures not directly linked to a surgical procedure are coded separately.

P02 Incomplete or suspended procedure

Take the following steps if a procedure was, for any reason, suspended or not completed:

1. Please determine whether an individual code in the CMP-CY is available in the event of a change from a laparoscopic/endoscopic procedure to "open surgery".
   a. Please use the specific code for "change to open surgery", if available.
   b. If a specific code for the change is not available, please **only** code the open surgical procedure.
2. Please use the specific code for an unsuccessful (failed) procedure (see example 1), if available.
3. If a CMP-CY code is available for an incomplete performance, please only code the incomplete performance (see example 2).
4. In all other cases, please code the scheduled, not the incomplete procedure.

Example 1

Specific codes are available for some unsuccessful (failed) procedures.

73.3 *Failed forceps*

Example 2

In cases where a laparotomy was performed to undertake an appendectomy, but the appendectomy could not be performed due to cardiac arrest, only the laparotomy is coded.

54.11 *Exploratory laparotomy*

P03 Multiple/bilateral procedures

Multiple procedures

The coding of procedures should reflect the time and effort involved, if possible. General multiple procedures should therefore be coded each time they are performed during the treatment phase.

Example 1

Non-drug eluting stents are inserted into various coronary arteries during different treatment sessions in a patient with chronic ischaemic heart disease.

Procedures:	36.06	*Insertion of non-drug-eluting coronary artery stent(s)*
	00.45	*Insertion of one vascular stent*
	36.06	*Insertion of non-drug-eluting coronary artery stent(s)*
	00.45	*Insertion of one vascular stent*

N.B.: Several treatment sessions during the course of an inpatient stay are coded using several codes.

Exceptions:

- The following should be coded **only once** during a **treatment session**: e.g. multiple excisions of skin lesions, multiple biopsies or similarly protracted procedures, if these procedures are performed at the same site.
- For pragmatic reasons, procedures coded **only once** during an **inpatient stay** should be coded with the date of the first procedure
  - if the code for these procedures states quantities (e.g. blood transfusions) or times (s.a. CCG P04 *Procedures, differentiated on the basis of extent, time or number* (page 15));
  - if instructions or guidelines stipulate that a code can be used only once, or if procedures during an inpatient stay are generally repeated.

Bilateral procedures

The CMP-CY stipulates the obligatory use of an additional code for procedures on bilateral organs or body parts, stating on which side the operation was performed ((**R**=right, **L**=left, **B**=bilateral). If a bilateral procedure is performed during the same treatment session, it should be additionally coded with a "B". Otherwise, the respective side on which the procedure was performed should be stated (**R, L**).

Example 2

Amputation of **both** lower legs

84.15 **B** *Other amputation below knee*

P04 Procedures, differentiated on the basis of extent, time or number

Certain CMP-CY procedures are differentiated based on extent, time or number.

Add quantities and/or dates and code the total once per hospital stay (s.a. CCG P03 *Multiple/bilateral procedures* (page 14)). For pragmatic reasons, please select the day of the first procedure as reference date.

Insofar as the CMP-CY requests data on dosages or amounts for the administration of medications or blood products, please **only code the dosage or amount actually administered to the patient**.

Example 1

99.040	*Transfusion of packed cells: not otherwise specified*
99.041	*Transfusion of packed cells: 1 to 5 units*
99.042	*Transfusion of packed cells: 6 to 10 units*
99.043	*Transfusion of packed cells: more than 10 units*

P05 Procedures normally not coded

The majority of procedure codes provided in the CMP-CY catalogue describe significant medical procedures that have to be coded according to CCG P01 *General coding guidelines for procedures* (page 13). However, some codes of CMP-CY are considered "routine" and thus insignificant procedures.

Coding of these routine procedures is not mandatory as resource consumption of these procedures is already reflected in diagnoses and/or associated procedures. Furthermore, routine procedures should not be coded as unspecified or residual codes (e.g. 99.99 *Other miscellaneous procedures*). Routine procedures can be defined as procedures, which are performed for most patients and/or repeatedly during hospitalization.

For example, the following procedures should normally not be coded:

57.94	*Insertion of indwelling urinary catheter*
57.95	*Replacement of indwelling urinary catheter*
87.49	*Other chest x-ray*
88.21	*Skeletal x-ray of shoulder and upper arm*
88.7-	*Diagnostic ultrasound*
89.52	*Electrocardiogram*
90.52	*Microscopic examination of blood: culture*
99.18	*Injection or infusion of electrolytes*
99.21	*Injection of antibiotic*

SPECIAL CODING GUIDELINES

S01 Mechanical ventilation

Definition

Mechanical ventilation (artificial respiration) is a procedure during which blood gases are moved into and out of the lungs by means of a mechanical device. Breathing is supported by increasing the patient's respiratory efforts or by replacing patient respiration. During artificial respiration, the patient is generally intubated or tracheotomised and is continuously respirated. In intensive care patients mechanical ventilation can also be effected via ventilation mask systems, if these masks are applied in lieu of the usual intubation or tracheotomy.

Coding

If the mechanical ventilation meets the above definition, please

1) record the **duration** of mechanical ventilation and
2) **in addition,** document

2a) one of the following codes

96.01 *Insertion of nasopharyngeal airway*
96.02 *Insertion of oropharyngeal airway*
96.03 *Insertion of esophageal obturator airway*
96.04 *Insertion of endotracheal tube*
96.05 *Other intubation of respiratory tract*

and/or

2b) the appropriate code from

31.1 *Temporary tracheostomy* or
31.2 *Permanent tracheostomy*

if a **tracheostoma** was inserted for artificial respiration.

3) Analogous to intensive-care patients, who are mechanically ventilated via ventilation mask systems, the same procedures apply **to residents in nursing homes who are artificially respirated via a tracheostoma**, i.e. ventilation times should be recorded if said residents are considered "patients receiving intensive care".

Calculation of mechanical ventilation hours

Mechanical ventilation (see definition, paragraph 1) initiated for surgery or started during surgery and lasting **no longer than 24 hours,** is **not included** in the total mechanical ventilation hours. Mechanical ventilation during general anaesthesia is considered to be an integral part of a surgical intervention.

If, however, mechanical ventilation initiated for surgery or started during surgery lasts **longer than 24 hours**, **it is included** in the total mechanical ventilation hours. In this case, the count of mechanical ventilation hours starts with intubation. The intubation should therefore be coded although it was initiated for surgery.

Mechanical ventilation not initiated for surgery, e.g. intensive care treatment following a head injury or burns, is always included in all ventilated hours irrespective of its duration. If already ventilated patients undergo surgery, the time in the operating theatre is part of all ventilated hours.

In the case of one/several ventilation period(s) during a hospital stay, all ventilated hours should be calculated in accordance with the above-mentioned guidelines and the total rounded up to the next

whole hour (s.a. CCG P04 *Procedures, differentiated on the basis of extent, time or number* (page 15) and CCG P03 *Multiple/bilateral procedures* (page 14)).

Start

Start the count at the time of one **of the following events**:

- **Endotracheal intubation**

  For patients requiring intubation for artificial respiration, start the count at the time they are connected to the respirator.

  Endotracheal tubes sometimes need replacing because of mechanical problems. The time it takes to remove and immediately replace endotracheal tubes is included in all ventilated hours, i.e. the count is therefore continued.

  The count of ventilated hours in patients under mechanical ventilation with endotracheal intubation subsequently undergoing a tracheotomy starts at the time of intubation. If tracheotomy is present, the duration of mechanical ventilation is added.

- **Ventilation via face masks**

  The count of ventilated hours starts at the time the patient is connected to the respirator.

- **Tracheotomy**

  (With subsequent start of mechanical ventilation). The count of ventilated hours starts at the time the patient is connected to the respirator.

- **Admission of ventilated patient**

  The count for patients admitted under mechanical ventilation starts at the time of admission (s.a. "transferred patients" below).

End

End the count of ventilated hours with **one of the following events**:

- **Extubation**
- **End of mechanical ventilation** following a weaning period.

  N.B.:

  The following applies to patients with tracheotomy (following a weaning period):

  In ventilated patients, the tracheal tube is left in place for a few days (or longer, e.g. in patients with neuromuscular conditions) following the end of mechanical ventilation. The count of ventilation hours ends with the termination of mechanical ventilation.

- **Discharge, death or the transfer** of a patient receiving mechanical ventilation**.**

The **method for weaning** from mechanical ventilation (e.g. CPAP, SIMV and PSV) is not coded.

The count of ventilation hours generally includes the **duration of weaning** (including ventilation-free intervals during the respective weaning period). Several attempts are possible to wean the patient off the respirator.

The end of weaning can only be determined retrospectively following the start of a stable respiratory status.

A patient is respiratorily stable when he/she has been able to breathe independently without a respirator over an extended period.

This period is defined as follows:

- For patients who were ventilated for **up to 7 days** (including weaning period): **24 hours**

- For patients who were ventilated for **more than 7 days** (including weaning period): **36 hours**

To calculate the number of hours of continuous mechanical ventilation during hospitalisation, begin counting the duration when mechanical ventilation is started. The duration ends when the mechanical ventilator is turned off (after the weaning period).

Example 1

A patient has been mechanically ventilated since July 5th. On July 10th, at 12.00 hours, the mechanical ventilator is turned off. On July 11th at 10:00 hours, the patient starts exhibiting respiratory instability and again requires mechanical ventilation (within the defined period of 24 hours of mechanical ventilation for up to 7 days). To calculate all ventilated hours, include the ventilator-free days from July 10th at 12:00 hours to July 11th, at 10:00 hours in the calculation.

Example 2

A patient has been mechanically ventilated since July 5th. On July 10th, at 12.00 hours, mechanical ventilator is turned off. On July 11th at 12:00 hours it is determined, that the patient is respiratorily stable and able to breathe independently (end of defined period of 24 hours of mechanical ventilation for up to 7 days). The count of ventilation hours ends on July 10th, at 12:00 hours. A new ventilation period starts if the patient needs to be mechanically ventilated again later (after July 11th, 12:00 hours).

Weaning a patient off the respirator also includes mechanical respiratory support by means of intermittent phases of assisted non-invasive ventilation/respiratory support with CPAP/ASB masks, or CPAP masks in turns with spontaneous breathing without mechanical support. Oxygen insufflation and/or inhalation via mask systems is, however, not included.

In special cases where patients are weaned from a respirator by means of intermittent mechanical ventilation using CPAP via facemask, alternating with periods of spontaneous breathing, ventilation hours can only be taken into account if a patient's spontaneous breathing period was supported by a CPAP mask for a total of at least **6** hours per calendar day.

In this case, the count of ventilation hours ends **with the last phase in the CPAP therapy** on the day on which the patient was last mechanically ventilated using **CPAP via facemask** for a total of at least **6** hours.

Example 3

A patient has been ventilated since July 2nd. During the weaning period, the patient is mechanically ventilated using CPAP via facemask

on July 10th for a total of 8 hours

on July 11th for a total of 6 hours (last phase of CPAP therapy ended at 22:00 hours)

on July 12th for a total of 4 hours

The count of ventilation hours including the weaning period thus ends on July 11th at 22:00 hours.

Continuous positive airway pressure (CPAP)

Ventilation hours are **not** coded, if CPAP is used to treat **adults, children and adolescents** for disorders such as sleep apnoea.

If, however, CPAP (CPAP masks) is applied as a method of weaning the patient from a respirator, the ventilation hours will be taken into account (see above) i.e. they are added to the total ventilation period (see: Definition of "mechanical ventilation", "method of weaning", "duration of weaning", "end of weaning").

S02 Diabetes mellitus

Principal diagnosis: Diabetes mellitus with complications

If a patient presents with a form of diabetes mellitus, which is assigned a code from E10.− to E14.− and complications of diabetes exist, it should be ascertained before assigning the appropriate code for diabetes manifestations, if

- the **treatment of the underlying diabetes mellitus** or
- the **treatment of one or several complications**

is mainly responsible for the patient's admission to hospital. It is also important for the coding process to ascertain **how many complications** of diabetes exist and whether these meet the **definition of secondary diagnosis**.

If the underlying disease diabetes mellitus is being treated, and **only one diabetes complication (manifestation)** exists, a code from E10–E14, fourth digit ".6" should be assigned (see example 1) (see different regulation on secondary diagnosis on page 23). A code for the manifestation should also be assigned if the manifestation meets the definition of secondary diagnosis (see example 2).

Example 1

A type 1 diabetes mellitus patient is admitted owing to severe metabolic imbalance. The only complication stated in the patient's medical history is diabetic retinopathy, which does not require treatment and therefore does not cause the utilisation of hospital resources.

Principal diagnosis:	E10.6	*Insulin-dependent diabetes mellitus with other specified complications*
Secondary diagnosis:	None	

This coding example demonstrates the existence of a documented diabetes complication (manifestation), which does not require treatment. The criteria, which will validate the inclusion of a secondary diagnosis are not met, therefore this complication (manifestation) is not coded separately.

Example 2

A patient with type 1 diabetes mellitus is admitted owing to severe metabolic imbalance. The only other complication is diabetic nephropathy, which is also treated.

Principal diagnosis:	E10.6†	*Insulin-dependent diabetes mellitus with other specified complications*
Secondary diagnosis:	N08.3*	*Glomerular disorders in diabetes mellitus*

N.B.: In this case, the code E10.6 is classified as "ethiology code" for the asterisk code N08.3* (manifestation) and should thus be marked with "†".

N.B.: In this instance, the fourth digit of the diabetes code ".6" is selected to differentiate between the treatment of diabetes with severe metabolic imbalance and the treatment of a complication (manifestation) (see also example 5), and to achieve the appropriate grouping in the DRG system. This coding instruction therefore depicts **an exception to the rules of ICD-10** for the coding of diabetes mellitus.

Code E10–E14, fourth digit ".7" is assigned **if the underlying disease diabetes mellitus is treated** and **multiple complications** (manifestations) exist, without a manifestation being at the forefront of therapy. Codes for the individual manifestations should also be assigned if they correspond to the definition of secondary diagnosis.

Example 3

A type 1 diabetes mellitus patient with multiple complications manifested in the form of atherosclerosis of the extremities arteries, retinopathy and nephropathy is admitted owing to severe metabolic imbalance. All present complications are also treated.

Principal diagnosis:	E10.7†	*Insulin-dependent diabetes mellitus with multiple complications*
Secondary diagnoses:	I79.2*	*Peripheral angiopathy in diseases classified elsewhere*
	H36.0*	*Diabetic retinopathy*
	N08.3*	*Glomerular disorders in diabetes mellitus*

N.B.: In this case, code E10.7 is classified as "ethiology code" and marked with "†". This "ethiology code" applies to all of the following asterisk codes (manifestations) up to the appearance of a new "†" code or a code without a tag. The ethiology of the manifestations I79.2*, H36.0* and N08.3* is thus coded with E10.7†.

If diabetes mellitus complications (manifestations) exist, and the treatment of **a manifestation** takes priority, the corresponding code from E10–E14, fourth digit, should be assigned, followed by the appropriate code for this manifestation. The codes for further manifestations should be assigned if they comply with the definition of secondary diagnosis.

Example 4

A patient with type 1 diabetes mellitus and peripheral vascular complications in the form of progressive diabetic angiopathy of the extremities arteries with pain at rest occurring over a period of several years is admitted for bypass surgery. His diabetic retinopathy with significant visual impairment is also treated.

Principal diagnosis:	E10.5†	*Insulin-dependent diabetes mellitus with peripheral circulatory complications*
Secondary diagnoses:	I79.2*	*Peripheral angiopathy in diseases classified elsewhere*
	I70.22	*Atherosclerosis of arteries of extremities: pelvis-leg type, with pain at rest*
	E10.3†	*Insulin-dependent diabetes mellitus with ophthalmic complications*
	H36.0*	*Diabetic retinopathy*
Procedure(s):	39.25	*Aorta-iliac-femoral bypass*

N.B.: The code I70.22 *Atherosclerosis of arteries of extremities: pelvis-leg type, with pain at rest* serves as an example for the more detailed description of the diagnosis characterised by the dagger-asterisk system. In this instance, it is not assigned as principal diagnosis.

If multiple diabetes mellitus complications (manifestations) exist, and the treatment of **several manifestations** takes priority, please follow the guidelines on "two or more diagnoses complying with the definition of principal diagnosis" in CCG D02 *Principal diagnosis* (page 3). The fourth digit of a code from E10–E14 should therefore be selected according to the manifestation, which the treating physician considers to be closest to the definition of principal diagnosis. The appropriate code for this manifestation is also assigned. The codes for further manifestations should be specified, if they comply with the definition of secondary diagnosis.

Diabetes mellitus as secondary diagnosis

If a patient is admitted to hospital for **any other reason than diabetes mellitus,** it is important to determine

- whether diabetes mellitus complies with the definition of secondary diagnosis,
- whether diabetes mellitus complications exist and
- whether these complications comply with the definition of secondary diagnosis

in order to identify the appropriate code.

If diabetes mellitus complies with the definition of secondary diagnosis, please code appropriately. In the case of complications (manifestations), the fourth digit of a code from E10–E14 should be assigned according to the manifestation(s). Please also specify manifestations, which comply with the definition of secondary diagnosis.

Notwithstanding the coding guidance on diabetes mellitus as principal diagnosis,

- .6 as fourth digit should not be recorded if a more specific code for an individual complication can be selected and/or
- multiple complications should always be coded with .7 as fourth digit.

Example 5

A patient with long-term arterial hypertension and intensive nicotine abuse is admitted for bypass surgery owing to the deterioration of documented peripheral artery occlusive disease (PAOD) with pain at rest. In addition, the patient also undergoes treatment for type 2 diabetes mellitus, incipient diabetic polyneuropathy and incipient diabetic retinopathy.

Principal diagnosis:	I70.22	*Atherosclerosis of arteries of extremities: pelvis-leg type, with pain at rest*
Secondary diagnosis:	I10	*Essential (primary) hypertension*
	E11.7†	*Non-insulin-dependent diabetes mellitus with multiple complications*
	G63.2*	*Diabetic polyneuropathy*
	H36.0*	*Diabetic retinopathy*
Procedure(s):	39.25	*Aorta-iliac-femoral bypass*

Diabetic foot syndrome

The diagnosis "diabetic foot" is coded with

E10–E14, **fourth digit**

".7" *Diabetes mellitus with multiple complications*

The codes for existing manifestations, for example

G63.2* *Diabetic polyneuropathy,*

I79.2* *Peripheral angiopathy in diseases classified elsewhere*

should be **stated thereafter**. All existing manifestations and complications should be coded, if they comply with the definition of secondary diagnosis.

Example 6

A patient with uncontrolled type 1 diabetes mellitus is admitted for the treatment of diabetic foot syndrome with a mixed ulcer in the toe (in connection with angiopathy and neuropathy) and erysipelas of the lower leg.

Principal diagnosis:	E10.7†	*Insulin-dependent diabetes mellitus with multiple complications*
Secondary diagnoses:	G63.2*	*Diabetic polyneuropathy*
	I79.2*	*Peripheral angiopathy in diseases classified elsewhere*
	I70.23	*Atherosclerosis of arteries of extremities: pelvis-leg type, with ulceration*
	A46	*Erysipelas*

N.B.: In this example, the code I70.23 *Atherosclerosis of arteries of extremities: pelvis-leg type, with ulceration* serves to demonstrate the more detailed specification of the diagnoses described by the dagger-asterisk system. It should not be assigned as principal diagnosis.

S03 HIV/AIDS

N.B.: References in this guideline to the code group "B20-B24" pertain to all codes in this group with the exception of **B23.0** ***Acute HIV infection syndrome***.

HIV codes comprise the following:

R75	*Laboratory evidence of human immunodeficiency virus [HIV]* (i.e. doubtful evidence following ambiguous serological test result)
B23.0	*Acute HIV infection syndrome*
Z21	*Asymptomatic human immunodeficiency virus [HIV] infection status* (i.e. infection status HIV positive, not specified)
B20–B24	*Human immunodeficiency virus [HIV] disease*

The codes R75, Z21, B23.0 and group B20–B24 are mutually exclusive and may not be listed together during the same inpatient stay.

Laboratory information regarding HIV – R75

This code is only assigned for patients whose HIV antibody test result does not clearly show whether the patient has an HIV infection. This is usually the case when a screening test for HIV shows a positive test result, but the confirmation test is either negative or unclear. The code R75 *Laboratory evidence of human immunodeficiency virus [HIV]* should not be assigned as principal diagnosis.

Acute HIV infection syndrome – B23.0

The code B23.0 *Acute HIV infection syndrome* will be added as secondary diagnosis to the codes for existing symptoms (e.g. lymphadenopathy, fever) or complication (e.g. meningitis) in the case of "acute HIV infection syndrome" (either confirmed or suspected).

N.B.: In general, symptoms are only to be coded if their origin is unknown. This coding instruction thus constitutes an exception to Section "Codes for symptoms, findings and ambiguously described medical conditions" in CCG D02 *Principal diagnosis* (page 3).

Example 1

An HIV-positive patient presents with lymphadenopathy and is diagnosed with acute HIV infection syndrome.

Principal diagnosis:	R59.1	*Generalized enlarged lymph nodes*
Secondary diagnosis:	B23.0	*Acute HIV infection syndrome*

Following the complete remission of the principal disease, almost all patients become asymptomatic and remain so for several years. In the event of future admissions, coding will be conducted in accordance with existing guidelines. Once the corresponding symptoms cease to exist, the code for "Acute HIV infection syndrome" (B23.0) is no longer used.

Asymptomatic HIV-Status – Z21

Z21 *Asymptomatic human immunodeficiency virus [HIV] infection*

should **not be routinely assigned** and may **only** be selected as secondary diagnosis **if** the treatment of a HIV-positive patient increases the utilisation of hospital resources even though he/she is not exhibiting any symptoms (see CCG D03 *Secondary diagnoses* (page 6)).

Since Z21 refers to asymptomatic patients admitted for the treatment of a medical condition not associated with the HIV infection, code Z21 is **not assigned as principal diagnosis**.

HIV disease (AIDS) – B20, B21, B22, B23.1, B23.2, B23.8, B24

The following codes are available for patients with an HIV-associated medical condition (this can be an AIDS-defined disease or not):

B20.−	*Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases*
B21.−	*Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms*
B22.−	*Human immunodeficiency virus [HIV] disease resulting in other specified diseases*
B23.1	*HIV disease resulting in (persistent) generalized lymphadenopathy*
B23.2	*HIV disease resulting in haematological and immunological abnormalities, not elsewhere classified*
B23.8	*HIV disease resulting in other specified conditions*
B24	*Unspecified human immunodeficiency virus [HIV] disease*

In this case, Codes R75 and Z21 are not assigned.

Code sequence and selection

If HIV disease is the medical condition mainly responsible for the patient's admission to hospital, the corresponding code from B20–B24 (except B23.0) will be assigned as principal diagnosis. For example, this would pertain to a patient admitted for anti-retroviral chemotherapy to treat the HIV infection.

If a manifestation of the documented HIV disease is mainly responsible for the patient's hospitalisation, the manifestation will be coded as principal diagnosis. A code from B20-B24 (except B23.0) will be assigned as secondary diagnosis.

Example 2

A patient presents with thrush associated with the documented HIV infection.

Principal diagnosis:	B37.0	*Candidal stomatitis*
Secondary diagnosis	B20.4	*HIV disease resulting in candidiasis*

In general, and contrary to the definition of secondary diagnosis (CCG D03 *Secondary diagnoses* (page 6)), all existing manifestations of HIV disease (AIDS) are coded.

S04 Neoplasms: Code selection and code sequence

Diagnoses

Codes are sequenced subject to the treatment during the respective hospital stay.

If a patient is admitted for diagnostic/treatment measures associated with a primary malignancy, the code for the primary malignancy is assigned as principal diagnosis.

Example 1

A patient is admitted for the treatment of a malignant brain tumour in the frontal lobe.

Principal diagnosis:	C71.1	*Malignant neoplasm of brain: Frontal lobe*

The malignant neoplasm must be coded as principal diagnosis every time the patient is hospitalised **for the treatment of a malignant neoplasm, for the required follow-up treatments** (e.g. operations, chemo/radiation therapy, other therapy) and **for diagnostic measures** (e.g. staging) (see example 2), until the treatment has been **concluded.**
This also applies to inpatient stays following the surgical resection of a malignant tumour even if the malignant tumour was surgically removed, since the patient is still undergoing tumour treatment. A principal diagnosis according to CCG D02 *Principal diagnosis* (page 3) should be selected if the patient's hospitalisation is neither due to the malignant condition nor to chemo or radiation therapy.

Example 2

A patient is admitted for the staging of Lymphocyte predominant Hodgkin's disease (LPHD) following chemotherapy.

Principal diagnosis:	C81.0	*Hodgkin's disease: Lymphocytic predominance*

If a patient requires one or several interventions for the treatment of a malignant neoplasm or metastases, the appropriate code for malignant neoplasm/ metastases should be assigned as the principal diagnosis for each further hospitalisation during which follow-up surgery is performed. Even if the malignant neoplasm/metastases was/were perhaps removed during the first surgical procedure, the **patient** is **still being treated for the consequences**, i.e. the malignant neoplasm/metastases is/are also the cause for follow-up surgery.

If a patient is merely admitted for the treatment of metastases, the appropriate code for the metastases should be assigned as principal diagnosis in addition to any documented secondary diagnosis/diagnoses for the primary tumour (see example 3). Even several years after the resection of the primary tumour, the primary malignancy is still classified as secondary diagnosis, since the patient is still being treated for the malignancy. C80 *Malignant neoplasm without specification of site* should be assigned if the site of the primary tumour is unknown.

Example 3

A patient is admitted for the resection of liver metastases, following transverse colon cancer surgery three months previously.

Principal diagnosis:	C78.7	*Secondary malignant neoplasm of liver*
Secondary diagnosis:	C18.4	*Malignant neoplasm of colon: Transverse colon*

If the patient is primarily admitted for systemic chemotherapy or "systemic" radiation therapy of the primary tumour and/or the metastases, the primary malignant neoplasm should be assigned as principal diagnosis. The metastasis is assigned as principal diagnosis if the patient is primarily admitted for systemic chemotherapy and the primary tumour is unknown.

Example 4

A patient is admitted for systemic chemotherapy of liver metastases, following transverse colon cancer surgery three months previously.

Principal diagnosis:	C18.4	*Malignant neoplasm of colon: Transverse colon*
Secondary diagnosis:	C78.7	*Secondary malignant neoplasm of liver*

If however a patient is admitted to hospital for local chemotherapy or local radiation therapy of the metastases, the metastases will be assigned as principal diagnosis and the primary tumour as secondary diagnosis (see coding in example 3).

If a patient is admitted for treatment of the primary tumour and the metastases, and two diagnoses simultaneously meet the criterion of principal diagnosis, the diagnosis, which in terms of the examination and/or the treatment causes the greater utilisation of hospital resources, is selected as principal diagnosis in accordance with CCG D02 *Principal diagnosis* (page 3).

Example 5

A patient with suspected liver metastases detected by sonography is admitted for a search for the primary tumour and further testing, ultimately revealing colon cancer with liver metastases. The surgeon performs a hemicolectomy and partial hepatectomy.

Principal diagnosis:	To be decided by the treating physician
Secondary diagnosis:	

If a patient presents with a symptom, and the underlying disease is known at the time of his/her admission to hospital, the symptom should be coded as principal diagnosis if only the symptom is treated. The underlying disease will be assigned as secondary diagnosis.

Example 6

A patient, who was diagnosed with a large malignant brain tumour with several overlapping lesions three months previously, is admitted to hospital following recurring convulsions. **Only the convulsions** are treated.

Principal diagnosis:	R56.8	*Other and unspecified convulsions*
Secondary diagnosis:	C71.8	*Malignant neoplasm: Overlapping lesion of brain*

Relapse of primary malignancy

The relapse of a primary malignancy, which had been radically resected earlier from the same organ or tissue, should be coded as primary malignant neoplasm of the stated site, i.e. a relapsed malignancy is coded like a primary tumour.

Example 7

A patient is hospitalised with relapsed gastric cancer two years after cancer surgery in the gastric body.

Principal diagnosis:	C16.2	*Malignant neoplasm: Body of stomach*

Extended excision of tumour

The appropriate code for the tumour should be assigned in the case of patients admitted for the extended excision of previously removed tumours, even if histopathological findings provide no evidence of a residual tumour.

S05 Personal (past) medical history of malignant neoplasm

Personal history of malignant neoplasm

A "personal history code" is assigned, if it can be assumed that the patient is definitely cured. At which time this is possible depends on the respective disease. Since this assessment can really only be made retrospectively, a "clinical" differentiation is made based on the continued treatment of the malignancy rather than on a stipulated period.

In cases where the treatment of the malignancy is concluded, a code from

Z85.– *Personal history of malignant neoplasm*

should be assigned as **secondary diagnosis**, if the required treatment time and effort (hospital resources) during the patient's current inpatient stay is increased (s.a. *Secondary diagnoses* (page 6)).

If a patient received no treatment for the primary malignancy over a certain period but subsequently developed metastases from this primary site, **codes from Z85.– should not be assigned**.

Follow-up examinations in patients with a personal history of malignant neoplasm

Codes of category

Z08.– *Follow-up examination after treatment for malignant neoplasms*

should only be assigned as **principal diagnosis** if a patient is admitted for the follow-up examination of a malignancy and **the tumour is no longer detectable**. The appropriate code from Category Z85.– *Personal history of malignant neoplasm* should be assigned as secondary diagnosis.

Example 1

A patient is admitted for a follow-up examination after radiotherapy in connection with a malignant neoplasm of the urinary tract (lateral wall of urinary bladder). A relapsed malignancy could not be found.

Principal diagnosis:	Z08.1	*Follow-up examination after radiotherapy for malignant neoplasm*
Secondary diagnosis:	Z85.5	*Personal history of malignant neoplasm of urinary tract*
Procedure(s):	57.32	*Other cystoscopy*

S06 Lymphoma

Lymphomas identified as "extranodal", or lymphomas that arise or present in non-lymphoid sites (e.g. the MALT lymphoma of the stomach), should be assigned the appropriate code from **categories** C81 to C88.

A lymphoma is not classified as metastatic, irrespective of the number of affected areas.

Lymphomas should <u>not</u> be assigned the following codes:

C77.– *Secondary and unspecified malignant neoplasm of lymph nodes*

C78.– *Secondary malignant neoplasm of respiratory and digestive organs*

C79.0 *Secondary malignant neoplasm of kidney and renal pelvis*

C79.1 *Secondary malignant neoplasm of bladder and other and unspecified urinary organs*

C79.2 *Secondary malignant neoplasm of skin*

C79.4 *Secondary malignant neoplasm of other and unspecified parts of nervous system*

C79.6 *Secondary malignant neoplasm of ovary*

C79.7 *Secondary malignant neoplasm of adrenal gland*

C79.8- *Secondary malignant neoplasm of other specified sites*

Please assign the following code to malignant bone lymphoma

C79.5 *Secondary malignant neoplasm of bone and bone marrow*
Bone (marrow) lesions in connection with malignant lymphomas (conditions classifiable under C81–C88)

An additional code is required if malignant neoplasms of lymphatic and haematopoietic tissue affect the cerebral meninges or the brain:

C79.3 *Secondary malignant neoplasm of brain and cerebral meninges*

S07 Cerebral infarction (stroke)

1. Acute cerebral infarction

A code from categories I60-I64 (cerebrovascular diseases) together with the appropriate code for the deficits (e.g. hemiplegia, aphasia, hemianopsy, neglect …) should be assigned as long as the patient is undergoing **continued** treatment for acute cerebral infarction and its direct sequelae (deficits).

Example 1

A patient is admitted for inpatient treatment following cerebral infarction with flaccid hemiplegia and aphasia.

Principal diagnosis:	I63.3	*Cerebral infarction due to thrombosis of cerebral arteries*
Secondary diagnoses:	G81.0	*Hemiplegia*
	R47.0	*Dysphasia and aphasia*

The cerebral infarction is coded as principal diagnosis and all other functional disorders as secondary diagnoses.

2. "Old cerebral infarction"

A patient with a history of cerebral infarction is admitted **with** current neurological deficits. The neurological deficits (e.g. hemiplegia, aphasia, hemianopsy, neglect …) are coded according to CCG D03 *Secondary diagnoses* (page 6) and a code from

I69.– *Sequelae of cerebrovascular disease*

is assigned thereafter.

Example 2

A patients is admitted with pneumococcal pneumonia after suffering acute cerebral infarction three years previously and taking thrombocyte aggregation inhibitors ever since to prevent a relapse. A residual spastic hemiparesis is still apparent, causing an increase in care costs.

Principal diagnosis:	J13	*Pneumonia due to Streptococcus pneumoniae*
Secondary diagnoses:	G81.1	*Spastic hemiplegia*
	I69.4	*Sequelae of stroke, not specified as haemorrhage or infarction*

S08 Tetraplegia/paraplegia and spinal cord injury

Initial (acute) phase of traumatic paraplegia/tetraplegia

The acute phase of a spinal cord injury is the treatment phase directly following the trauma, possibly involving several hospital stays.

The following details should be coded if a patient is admitted to hospital following a spinal cord injury (e.g. with spinal cord compression, contusion, rupture, paraplegia or tetraplegia):

1. The code for the type of spinal cord lesion should be assigned first (complete or incomplete paraplegia).

Patients with spinal cord injuries most probably suffered a vertebral fracture or luxation in which case the following details should be coded.

2. The site of the fracture, if the patient suffered a vertebral fracture
3. The site of the luxation, if the patient suffered a luxation.

Example 1

A patient is admitted with a closed compression fracture at T12. A spinal cord compression injury is diagnosed at the same level, together with incomplete paraplegia at the functional height L2.

Principal diagnosis:	S24.1	*Other and unspecified injuries of thoracic spinal cord*
Secondary diagnosis:	S22.00	*Fracture of thoracic vertebra: closed*

Initial (acute) phase of non-traumatic paraplegia/tetraplegia

The "acute" phase of non-traumatic paraplegia/tetraplegia comprises first admissions owing to a non-traumatic functional defect, e.g. transverse myelitis or spinal cord infarction. It can, however,

also involve a conservatively or surgically treated condition which is either in remission or has deteriorated, now requiring the same treatment intensity as with patients admitted for trauma treatment for the first time.

The following codes should be assigned if a patient presents with a disease resulting in acute spinal cord injury (e.g. myelitis):

The disease as principal diagnosis, for example

G04.9 *Encephalitis, myelitis and encephalomyelitis, unspecified*

and a code from

G82.– *Paraplegia and tetraplegia*, fifth digit ".0" or ".1".

Late (chronic) phase of (non traumatic/traumatic) paraplegia/tetraplegia

The chronic phase of paraplegia/tetraplegia is deemed to have been reached when the treatment of the acute medical condition (e.g. myelitis or an acute spinal cord injury) which caused the paralysis is concluded.

A code from category

G82.– *Paraplegia and tetraplegia*, fifth digit ".2" or ".3",

should be assigned as principal diagnosis if a patient is admitted for treatment of paraplegia/tetraplegia during the chronic phase.

If, however, a patient is admitted for the treatment of another condition, e.g. urinary tract infection, femur fracture, etc., the appropriate code for the condition together with a code from category

G82.– *Paraplegia and tetraplegia*, fifth digit ".2" or ".3",

should be selected in addition to the codes for other current conditions. Diagnoses should be correctly sequenced based on the definition of the principal diagnosis.

The codes for spinal cord injury and for conditions resulting in acute spinal injuries should not be selected, since they are only assigned during the acute phase.

Example 2

A patient is admitted for the treatment of urinary tract infection. In addition, the patient is suffering from incomplete flaccid paraplegia at L2 level, incomplete cauda equina syndrome and neurogenic urination disorder.

Principal diagnosis:	N39.0	*Urinary tract infection, site not specified*
Secondary diagnoses:	G82.03	*Flaccid paraparesis and paraplegia: chronic incomplete paraplegia*
	G83.4	*Cauda equina syndrome*
	G95.8	*Other specified diseases of spinal cord*

N.B.: Please sequence the additional code G95.8 if the neurogenic urination disorder is to be specified.

S09 Ischaemic heart disease (coronary artery disease)

Angina pectoris (I20.–)

If a patient is diagnosed with angina pectoris, please assign the appropriate code and sequence it **before** the code for coronary atherosclerosis.

If a patient presents with instable angina pectoris and develops myocardial infarction during his/her stay in hospital, only code the myocardial infarction.

S10 Cardiac arrest

Cardiac arrest, or cardiac arrest and apnoea (I46.– *Cardiac arrest*) should **only** be coded in the event that resuscitation measures are initiated, irrespective of the result for the patient.

Cardiac arrest (I46.– *Cardiac arrest*) should **not** be coded as principal diagnosis if the underlying cause is known.

S11 Cardiac pacemaker/Defibrillator

N.B.: This guideline comprises information on the coding of diagnoses and procedures in connection with pacemakers. This information equally applies to the coding of implantation, change and removal of a defibrillator.

Permanent pacemakers

If a **temporary probe is removed and a permanent pacemaker implanted**, the permanent pacemaker should be coded as first implantation, not as a replacement.

A pacemaker is routinely **inspected** during a patient's hospitalisation for pacemaker implantation. Assigning a procedure code is therefore not required.

The code

Z45.0 *Adjustment and management of cardiac pacemaker*

is assigned as principal diagnosis together with the appropriate procedure codes if a patient is **admitted for a change of pacemaker/defibrillator aggregates.**

S12 Gastrointestinal haemorrhage

If a patient is admitted for the diagnostic assessment of upper gastrointestinal (GI) bleeding, and an ulcer, erosions or varices are found during the endoscopic inspection, the finding is coded "with bleeding"; e.g. an acute ventricular ulcer with bleeding will be coded as follows:

K25.0 *Gastric ulcer, acute with haemorrhage*

A reflux oesophagitis with bleeding will be coded as follows:

K21.0 *Gastro-oesophageal reflux disease with oesophagitis* and

K22.8 *Other specified diseases of oesophagus*

It is assumed that the bleeding of the lesion as per endoscopy report can be assigned, even if the bleeding neither occurred during the examination nor during the patient's hospitalisation.

Not all categories available for the coding of gastrointestinal lesions supply a code with the modification "with bleeding". In such cases, an additional code will be used from category

K92.– *Other diseases of digestive system*

The following code will be used if the bleeding source **cannot** be determined or the respective examination was not performed during active renal bleeding:

K92.2 *Gastrointestinal haemorrhage, unspecified*

In this case, the code

K62.5 *Haemorrhage of anus and rectum*

will **not** be assigned.

However, in the event that a patient is examined for tarry stool (melaenaor faecal occult blood), one cannot simply assume that the endoscopically determined lesion is indeed the cause for the tarry stool or faecal occult blood. If there is no causal relationship between the symptom and the result of the examination, then the symptom must be coded first, followed by the examination result.

Patients with a history of recent gastrointestinal bleeding are sometimes admitted for endoscopic inspection to determine the bleeding source but do not exhibit any bleeding during the examination. If a clinical diagnosis is made based on knowledge obtained from the patient's case history or from other evidence, then the fact that there was no bleeding episode during the patient's hospitalisation does not a priori exclude entering a code with the modification "with bleeding". The same applies to the assignment of a code from category K92.– (*Other diseases of digestive system*) in cases where the reason for the previous bleeding episode could not be determined.

S13 Dialysis

Diagnoses

The principal diagnosis in patients admitted for dialysis depends on the duration of their hospital stay.

a) A **one-day stay** in hospital (admission and discharge on the same day, or on the next day following night dialysis) is coded as principal diagnosis using the code

   Z49.1 *Extracorporeal dialysis,*

   the underlying disease is coded as secondary diagnosis.

b) The code for the medical condition leading to hospitalisation is assigned as principal diagnosis in the case of **hospitalisations lasting several days** (discharge either on the day following admission or later).

   Z49.1 *Extracorporeal dialysis* and Z99.2 *Dependence on renal dialysis* will not be assigned.

Procedures

The fifth digit of the codes for **continuous** hemofiltration (39.955, 39.956), hemodialysis (39.952, 39.953) and peritoneal dialysis (54.982, 54.983) identifies the duration of the sessions.

The duration of treatment should be identified from beginning to end. A code should be assigned to each session (no addition of treatment times) in the case of several sessions as part of a continuous process of dialysis during a hospital stay. Recoding is not required in the event of a filter change or a similar, technically required interruption of a continuous process.

S14 Outcome of delivery

The hospital at which a delivery takes place will assign the appropriate code for **each** birth from

Z37.–! *Outcome of delivery*

to the mother's data. This code may not be assigned as principal diagnosis.

S15 Duration of pregnancy

A code from

O09.–! *Duration of pregnancy*

for the duration of pregnancy will be assigned to the mother's basic data at the time of admission.

S16 Complications during pregnancy

Chapter XV comprises two areas for the coding of complications during pregnancy:

O20–O29 *Other maternal disorders predominantly related to pregnancy*

and

O94–O99 *Other obstetric conditions, not elsewhere classified.*

It is possible to assign a special code from 020-029 to medical conditions which predominantly occur in connection with a pregnancy.

Example 1

A patient is admitted during her 30th week of pregnancy for the treatment of pre-existing, insulin-dependent type 1 diabetes mellitus.

Principal diagnosis: O24.0 *Pre-existing diabetes mellitus, insulin-dependent*

Type 1 diabetes mellitus, aggravated by pregnancy, is represented by a code in Chapter XV (O24.0 *Pre-existing diabetes mellitus, insulin-dependent*).

The following code

O26.8 *Other specified pregnancy-related conditions*

is assigned in the case of diffuse symptoms in connection with a pregnancy for which a specific cause cannot be found.

Please refer to categories

O98.– *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium*

and

O99.– *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium*

for the coding of other complications in connection with a pregnancy (or conditions deteriorating during pregnancy or are the main reason for support during labour). They should be assigned together with a secondary diagnosis code for the respective medical condition from other ICD-10 chapters (see example 2).

Example 2

A patient is admitted in the 30th week of pregnancy owing to allergic bronchial asthma complicating pregnancy.

Principal diagnosis:	O99.5	*Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium*
Secondary diagnosis:	J45.0	*Predominantly allergic asthma*

Pregnancy as secondary diagnosis

If a patient is admitted for the treatment of a medical condition, which is neither complicated by the pregnancy nor complicates the pregnancy, the code for the respective medical condition is assigned as principal diagnosis together with

Z34.– *Supervision of normal pregnancy*

as secondary diagnosis.

Example 4

A patient is admitted in the 30th week of pregnancy with a closed metacarpal fracture.

Principal diagnosis:	S62.30	*Fracture of other metacarpal bone: closed*
Secondary diagnosis:	Z34.0	*Supervision of normal first pregnancy*

S17 Neonates

Codes from Z38.– should **not** be assigned if treatment is effected during the second or any subsequent hospitalisation.

Example 1

On the second day following a caesarean section, a male neonate is transferred from Hospital A to Hospital B owing to respiratory distress syndrome and pneumothorax.

Hospital A:

Principal diagnosis:	P22.0	*Respiratory distress syndrome of newborn*
Secondary diagnoses:	P25.1	*Pneumothorax originating in the perinatal period*
	Z38.0	*Singleton, born in hospital*

Hospital B:

Principal diagnosis:	P22.0	*Respiratory distress syndrome of newborn*
Secondary diagnosis:	P25.1	*Pneumothorax originating in the perinatal period*

S18 Multiple injuries

Diagnoses

Whenever possible, code **individual** injures as accurately as possible according to the bodily location and type of injury.

Combined categories for multiple injuries (T00–T07 *Injuries involving multiple body regions*) and codes from S00–S99 which are assigned for multiple injuries using a "7" as the fourth digit, may only be selected if the number of injuries to be coded exceed the maximum number of assignable diagnoses. In this instance, select specific codes (injury according to location/type) for serious injuries and multiple categories to code less severe injuries (e.g. surface injuries, open wounds, distortion and sprain).

N.B.: The alphabetic index of ICD-10 suggests assigning code T07 (*Unspecified multiple injuries*) to "multiple injuries" or "polytrauma". This code is unspecific and should **not** be assigned if possible.

Example 1

A patient presents with focal brain contusion, the traumatic amputation of an ear, 20-minute loss of consciousness, contusions of face, throat and shoulder as well as cheek and thigh lacerations.

Principal diagnosis:	S06.30	*Focal brain injury: without open intracranial wound*
Secondary diagnoses:	S06.70	*Intracranial injury with prolonged coma: without open intracranial wound*
	S08.1	*Traumatic amputation of ear*
	S01.4	*Open wound of cheek and temporomandibular area*
	S71.1	*Open wound of thigh*
	S00.8	*Superficial injury of other parts of head*
	S10.0	*Contusion of throat*
	S40.0	*Contusion of shoulder and upper arm*

In this case, S09.7 *Multiple injuries of head* und T01.8 *Open wounds involving other combinations of body regions* is **not** selected since individual codes should be assigned whenever possible.

S19 Burns and corrosions

Code sequences

If more than one burn/corrosion is present, sequence the highest degree of burn/corrosion first. Therefore, a third-degree burn/corrosion is sequenced **before** a second-degree burn/corrosion, even if the second-degree burn/corrosion affects a larger area of the body surface

In the case of burns/corrosions at the same site but of different degrees, code only the highest degree burn/corrosion.

Example 1

A second- and third-degree burn of the ankle is coded with

Principal diagnosis: T25.3 *Burn of third degree of ankle and foot*

Burns/corrosions requiring skin transplantation are always sequenced **before** those not requiring skin transplantation.

If several burns/corrosions **of the same degree** are present, sequence the area affecting the largest area of the body surface first. All other burns/corrosions should be coded according to their respective site whenever possible.

Example 2

A second-degree burn of the abdominal wall and the hand should be coded as follows:

Principal diagnosis:	T21.2	*Burn of second degree of trunk*
Secondary diagnosis:	T23.2	*Burn of second degree of wrist and hand*

It is expedient to use the codes for multiple sites burns or corrosions (T29.− *Burns and corrosions of multiple body regions*) if the number of codes for an inpatient stays exceed the maximum number of assignable diagnoses. Always use differentiated codes when dealing with third-degree burns/corrosions. If multiple codes are required, use them for coding second-degree burns/corrosions.

Body surface area (BSA)

Each burn/corrosion is **also** assigned a code from

T31.–! *Burns classified according to extent of body surface involved*

and/or

T32.–! *Corrosions classified according to extent of body surface involved*

to document the percentage of the affected body surface area.

The fourth digit represents the sum of all individual burns/corrosions in percent of body surface area.

A code from T31.–! and T32.–! should only be assigned once following the last code for the affected areas.

ADDITIONAL CODE INFORMATION

Calculation of effort points for complex intensive care unit interventions

The number of effort points for complex intensive care unit interventions is calculated from the sum of daily SAPS II (Simplified Acute Physiology Score) (without Glasgow Coma Scale) over the entire ICU stay (total SAPS II), plus the sum of 10 complex treatments (determined on a daily basis) from the TISS catalogue over the entire ICU stay.

The daily SAPS II is calculated in accordance with the following tables. The worst values over the last 24 hours are recorded respectively.

	Points												
Variables	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**9**	**10**	**11**	**12**	**13**
Heart rate [1/min]	70 – 119		40 – 69		120 – 159			≥ 160			<40		
Systolic blood pressure [mmHg]	100 – 199		≥ 200			70 – 99							<70
Body temperature [°C]	< 39			≥ 39									
PaO_2/FiO_2 * [mmHg]							≥ 200		100-<200		<100		
Urine output [l/d]	≥ 1.0				0.5 - <1.0						<0.5		
Serum urea level [g/l]	<0.6						0.6 - <1.8			≥1.8			
Leucocytes [$10^3/mm^3$]	1.0 - < 20			≥ 20								<1.0	
Serum potassium level [mmol/l]	3.0 - < 5.0			≥ 5.0 < 3.0									
Serum sodium level [mmol/l]	125 - <145	≥ 145				< 125							
Serum bicarbonate [mmol/l]	≥ 20			15 - < 20			< 15						
Serum bilirubin [µmol/l]	< 68.4				68.4 - <102.6				≥102.6				

*Assessment only in case of artificial ventilation

	Points					
Variables	**0**	**6**	**8**	**9**	**10**	**17**
Chronic diseases				Metastasizing neoplasia	Haematological neoplasia	AIDS*
Admission status **	Surgical intervention planned	Medical	Surgical intervention not planned			

*	Evaluation in case of positive HIV test and respective clinical complications
**	Surgical intervention planned: schedule date for surgical intervention at least 24 hours beforehand
	Surgical intervention not planned: date of surgical intervention only scheduled within the last 24 hours
	Medical: no surgical intervention for at least one week
N.B.!	Chronic diseases: Please only calculate the disease, which is allocated the highest number of points.

	Points								
Variables	0	5	7	12	13	15	16	18	26
Patient age	<40		40-59	60-69		70-74	75-79	≥80	

Only the ten most complex characteristics are recorded from the TISS-28:

Effort	**Points per day**
Artificial respiration	5
Infusion of multiple catecholamines (>1)	4
Liquid replacement in high quantities (>5 l/24 hours)	4
Peripheral arterial catheter	5
Left atrial catheter/pulmonary artery catheter	8
Haemofiltration/dialysis	3
Intracranial pressure measurement	4
Treatment of metabolic acidosis/alkalosis	4
Special interventions in ICU (e.g. tracheotomy, cardioversion)	5
Procedures outside the ward (diagnostics/operation)	5

Complex treatment in intensive medical care unit (basic procedure)

Exclusive

- Intensive monitoring without acute treatment of vital organ systems or short-term (< 24 hours) intensive treatment
- Short-term (< 24 hours) stabilisation of patients following surgical interventions

Please note the following:

Minimum characteristics

- Continuous 24-hour monitoring and emergency stand-by treatment by a team of nurses and doctors experienced in intensive medical care and aware of their patients' current problems;
- The continuous presence of a physician in the intensive care unit must be ensured.
- The number of effort points (EP) is calculated from the sum of daily SAPS II (without Glasgow Coma Scale) over the entire ICU stay (total SAPS II) plus the sum of 10 complex treatments per day from the TISS catalogue over the entire ICU stay.
- Please refer to the CMP-CY Instructions for Use regarding the use of SAPS II and TISS parameters.
- Special intensive medical procedures, such as transfusion of plasma and plasma components, plasmapheresis and immune adsorption, reanimation measures etc. are to be coded separately.
- This code must be used for patients older than 14 years of age.

96.811 *Complex treatment in intensive medical care unit (basic procedure): 1 to 184 effort points*
96.812 *Complex treatment in intensive medical care unit (basic procedure): 185 to 552 effort points*
96.813 *Complex treatment in intensive medical care unit (basic procedure): 553 to 828 effort points*
96.814 *Complex treatment in intensive medical care unit (basic procedure): 829 to 1104 effort points*
96.815 *Complex treatment in intensive medical care unit (basic procedure): 1105 to 1380 effort points*
96.816 *Complex treatment in intensive medical care unit (basic procedure): 1381 to 1656 effort points*
96.817 *Complex treatment in intensive medical care unit (basic procedure): 1657 to 1932 effort points*
96.818 *Complex treatment in intensive medical care unit (basic procedure): 1933 to 2208 effort points*
96.819 *Complex treatment in intensive medical care unit (basic procedure): 2209 to 2484 effort points*
96.820 *Complex treatment in intensive medical care unit (basic procedure): 2485 to 2760 effort points*
96.821 *Complex treatment in intensive medical care unit (basic procedure): 2761 to 3220 effort points*
96.822 *Complex treatment in intensive medical care unit (basic procedure): 3221 to 3680 effort points*
96.823 *Complex treatment in intensive medical care unit (basic procedure): 3681 to 4600 effort points*
96.824 *Complex treatment in intensive medical care unit (basic procedure): 4601 to 5520 effort points*
96.825 *Complex treatment in intensive medical care unit (basic procedure): 5521 to 7360 effort points*
96.826 *Complex treatment in intensive medical care unit (basic procedure): 7361 to 9200 effort points*
96.827 *Complex treatment in intensive medical care unit (basic procedure): more than 9200 effort points*

Neurological complex treatment of acute apoplexy

Please note the following:

Minimum characteristics

Treatment in a specialised unit by a *stroke multidisciplinary team under the expert guidance of a neurologist with*

- 24-hour physician on call is required (Monday to Friday at least 12-hour on-call duty during the day; the physician can be a specialist or a senior house officer/ junior doctor undergoing training within a certain speciality). During this time, the respective physician in the specialised unit attends to stroke patients exclusively and does not perform any other tasks. He may leave this specialised unit only to examine, take over or attend to stroke patients. During the 12-hour on-call night duty and during the 24-hour on-call duty at weekends and public holidays, the physician on call in the specialised unit may also attend to other neurological patients provided they are in the proximity, thus enabling him to attend to stroke patients in the specialised unit at any time.
- 24-hour monitoring of at least six of the following parameters: blood pressure, heart rate, ECG, respiration, oxygen saturation, temperature, intracranial pressure, EEG, evoked potential/responses,
- 6-hour monitoring (except during the night) and documentation of neurological findings for the early detection of stroke-in-progression, stroke relapse or any other complications,
- Computer tomography or magnetic resonance imaging of head; within 60 minutes if lysis is indicated, otherwise within 6 hours following admission,
- Neurosonological examination including transcranial Doppler sonography,
- Aetiological diagnostics and differential diagnosis of stroke (e.g. transesophageal echocardiogram, haemostaseology, angiitis diagnostics, EEG and other procedures) on the premises,
- 24-hour-availability of cerebral angiography,
- Continuous possibility of fibrinolytic therapy for the management of stroke,
- Immediate start of physiotherapy, neuropsychology, ergo therapy or speech therapy measures with at least one treatment unit per day in the stated areas if corresponding deficit is present,
- Immediate access to neurosurgical emergency measures and vascular-surgical and interventional-neuroradiological treatment measures (in respective in-house units or in partner hospitals with a transport time of no more than half an hour irrespective of the mode of transport).

96.841 *Neurological complex treatment of acute apoplexy: at least 24 to 72 hours at most*
96.842 *Neurological complex treatment of acute apoplexy: more than 72 hours*

Multimodal pain therapy

Please note the following:

Interdisciplinary therapy of patients with chronic pain (including tumour pain) lasting at least seven days with the participation of at least two specialist disciplines, one of which should be either a psychiatric, psychosomatic or psychological discipline, according to treatment plan under medical supervision, is to be coded for patients exhibiting at least three of the following characteristics:

- manifest or impending impairment of life quality/and or ability to work
- failure of previous unimodal pain therapy, pain-related surgical intervention or detoxification treatment
- existing prescription drug addiction
- serious mental concomitant disease
- serious somatic concomitant disease

This code requires interdisciplinary diagnostics by at least two specialist disciplines (a psychiatric, psychosomatic or psychological discipline is obligatory) and the concurrent application of at least three of the following active therapies: psychotherapy (behaviour therapy), special physiotherapy, relaxation measures, ergo therapy, medical training therapy, sensomotoric training, workplace therapy, art or music therapy or other exercise therapies. It also includes monitoring the treatment course by means of a standardised therapeutic assessment with interdisciplinary team consultation.

The application of this code is subject to the additional qualification “special pain therapy” of the person in charge.

94.391 *Multimodal pain therapy: at least 7 to 13 treatment days at most*

94.392 *Multimodal pain therapy: at least 14 to 20 treatment days at most*

94.393 *Multimodal pain therapy: at least 21 treatment days*

Implantation or change of a tumour endoprothesis

Please note the following.

This is an additional code. It is to be used exclusively for implantation or change of metal bone/joint replacements following the resection of primary and secondary malignant bone tumours.

The metal bone/joint replacement corresponds to the length and thickness of the removed bone.

81.991 *Implantation or change of a tumour endoprothesis*

Non-complex chemotherapy

Includes the following:

One or several days of non-complex chemotherapy

Excludes the following:

- Intrathecal cytostatic injection
- Administration of oral cytostatics
- Administration of steroids
- Administration of anti-bodies

Please note the following:

This code is to be used for subcutaneous or intravenous one-day chemotherapy with one or two medications. Each treatment block (one or several consecutive days) must be coded once. If a series of chemotherapy sessions take place on several, non-consecutive days (e.g. days 1, 8, 15), each session has to be coded individually.

99.251 *Non-complex chemotherapy*

Moderately complex and intensive blocks of chemotherapy

Includes the following:

E.g., 2- to 4-day blocks of chemotherapy

Excludes the following:

- Intrathecal cytostatic injection
- Administration of oral cytostatics
- Administration of steroids
- Administration of anti-bodies

Please note the following:

At least two cytostatics are administered intravenously during a block of chemotherapy, or complex and intensive chemotherapy is performed with extensive level-dependent treatment (e.g. HD methotrexate with level-dependent folinic acid rescue)

99.252 *Moderately complex and intensive blocks of chemotherapy*

Highly complex and intensive blocks of chemotherapy

Includes the following:

E.g., 5- to 8-day blocks of chemotherapy

Excludes the following:

- Intrathecal cytostatic injection
- Administration of oral cytostatics
- Administration of steroids
- Administration of anti-bodies

At least two cytostatics are administered intravenously during a block of chemotherapy

99.253 *Highly complex and intensive blocks of chemotherapy: one block of chemotherapy during an inpatient stay*

99.254 *Highly complex and intensive blocks of chemotherapy: two blocks of chemotherapy during an inpatient stay*

INDEX OF KEY WORDS

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