



Western Australian Coding Rule

0116/01 Anaemia with iron deficiency

Q.

Can D50.9 *Iron deficiency anaemia, unspecified* be assigned when anaemia and iron deficiency are documented separately in the medical record or should it only be assigned when the term 'iron deficiency anaemia' is documented?

A.

Iron deficiency is defined as a decreased total iron body content. Iron deficiency anaemia develops when body stores of iron drop too low to support normal red blood cell production. Iron deficiency may be present without causing anaemia. Anaemia may also be caused by factors other than iron deficiency.

Iron deficiency may be present with anaemia of another, or unspecified, cause. Therefore, it is inappropriate to assign D50.9 *Iron deficiency anaemia, unspecified* when the two conditions are documented separately in the medical record. As per the Index pathway 'Anaemia/iron deficiency', D50.9 *Iron deficiency anaemia, unspecified* should only be assigned for documentation of iron deficiency anaemia.

DECISION

D50.9 *Iron deficiency anaemia, unspecified* should only be assigned for documentation of iron deficiency anaemia. If the diagnostic statements of 'anaemia' or 'low haemoglobin' or '↓ Hb' and 'iron deficiency' are documented separately in the medical record, a clinician query is warranted to ascertain whether the patient has iron deficiency anaemia.

[Effective 23 Nov 2016, ICD-10-AM/ACHI/ACS 9th Ed.]