Government of **Western Australia**
Department of **Health**

Guide to Major Eleventh Edition Changes:

ACS 0002 *Additional diagnoses*

WA Clinical Coding Authority

Purchasing and System Performance Division

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Contents

Introduction

The general intent of ACS 0002 *Additional diagnoses* is unchanged: clinical coding is not intended to describe the current disease status of the patient – rather the conditions that are **significant** in terms of treatment, investigation and resources used in that episode.

It is acknowledged that 'significance' of a condition is difficult to define for classification purposes, therefore the changes to ACS 0002 aim to assist in identification of conditions or symptoms that are minor or trivial and have no significant impact on the episode, and therefore do not meet criteria for coding.

It should be noted that a condition may be documented by a clinician due to its clinical significance, however, it may not meet the criteria for coding in ACS 0002. Detail and examples have been added to further clarify each of the following ACS 0002 criteria:

1. Commencement, alteration or adjustment of therapeutic treatment (see Table 1)
2. Diagnostic procedures (see Table 2)
3. Increased clinical care (see Table 3) (Note: 'and/or monitoring' has been deleted from this criterion)

- The *Multiple Coding* section of ACS 0002 has been deleted. Refer instead to:
  - *Conventions used in the Tabular List of Diseases, Multiple condition coding*
  - ICD-10-AM Tabular List Instructional notes
  - Australian Coding Standards

- The following sections of ACS 0002 *Additional diagnoses* discuss conditions that have been identified as mandatory for coding:
  - *Additional diagnosis reporting referred to in other standards* and
  - *Supplementary codes for chronic conditions*

  Mandatory conditions should always be coded when documented. In the ACCD's 11th Edition public consultation process, it was clarified that documentation of a mandatory condition may be from any clinician (medical officer, allied health, midwife, nurse).

- A new section has been added: *Family and personal history and certain conditions influencing health status (Z80-Z99)* instructing to assign additional diagnosis codes for personal/family history or status, when the history or status is **relevant** to a condition being managed or an intervention being performed in the current episode of care. ACS 2112 *Personal history* has been deleted.

- The following specialty standards are now considered redundant and have been deleted: ACS 1336 *Hypertonia*, ACS 1342 *Hyperreflexia*, and ACS 1808 *Incontinence*.

Table 1. Conditions requiring commencement, alteration or adjustment of therapeutic treatment

	Routine therapeutic treatment NOT CODED	Significant therapeutic treatment CODED
Transient symptom / condition	Transient symptom or condition that is successfully treated with administration of medication alone, **without** need for investigation, care plan or further consultation. Example: Ranitidine administered for reflux, without investigation or care plan. No further consultation after medication administered.	Symptom or condition requiring administration of medication **with** investigation or a care plan. **or** Transient symptom or condition treated with medication that requires further assessment by a clinician (i.e. no longer considered transient), **with:** a diagnostic or therapeutic intervention undertaken; or a care plan prescribed. Example: Phenergan 25mg given for insomnia. Subsequent continued insomnia requiring further assessment by medical officer, with Phenergan dose increased.
Pre-existing condition	**Pre-existing condition requiring administration of ongoing medication.** This includes where ongoing medication is adjusted for management of another condition. Example: Patient has pre-existing hypertension. The patient's usual dose of antihypertensive is withheld due to episodes of hypotension, which eventually resolve and the patient is discharged on the original antihypertensive dose. Hypertension is not coded, therefore a supplementary U code is assigned. Hypotension is coded as it was managed with a medication change. **Pre-existing condition resulting in a minor adjustment to diagnostic work-up or care plan.** Example: ordering a non-contrast CT scan instead of a contrast CT scan in a patient with chronic kidney disease.	**Pre-existing condition requiring adjustment of medication specifically for that condition.** Example: Patient on antihypertensives for hypertension. During the episode, hypotension was managed with reduction of anti-hypertensive dose. Reduced dose administered for several days with regular blood pressure monitoring. Clinician documented that patient's hypertension was adequately controlled on the reduced dose, unnecessary to return to original dose. Hypotension coded as it was managed with a medication change. Hypertension is also coded as there was alteration of therapeutic treatment (medication decrease). **Pre-existing condition resulting in a major variation to the care plan for another condition.** Example: procedure delayed, cancelled or abandoned due a pre-existing condition; or change to surgical approach or type of operation performed due to a pre-existing condition.
Condition managed by nurse	**Condition managed with nurse-initiated medication or intervention alone.** Example: Nurse-initiated treatment of head lice with head-lice shampoo, without need for subsequent consultation, investigation or plan of care by a medical officer.	**Condition managed with nurse-initiated medication or intervention, if the condition requires subsequent assessment by a clinician/team** and diagnostic or therapeutic intervention(s) performed or a care plan commenced. Example: Nurse initiated Coloxyl and Senna for constipation. Constipation persisted and received assessment by medical officer who documented constipation and ordered a fleet enema.

Table 2. Conditions requiring a diagnostic procedure

	Diagnostic procedure routinely ordered NOT CODED	Diagnostic procedure specifically ordered CODED
Finding / condition being investigated	**A finding or diagnosis garnered from a routinely run diagnostic procedure alone**, cannot be coded using the criterion *Diagnostic procedure* because the condition was incidentally found on routine testing. Example: mild anaemia identified on routine FBC. No further investigation or management of anaemia. Anaemia is not coded. See also the *Incidental findings and conditions* section of ACS 0002.	**When a diagnostic procedure is ordered or performed specifically to establish a diagnosis; or provide specificity (including severity) to an established diagnosis;** the condition has met the criterion *Diagnostic procedure*. Example: anaemia identified on routine FBC, with subsequent order to repeat FBC during the episode. Anaemia is coded because a diagnostic procedure has been ordered to provide specificity on the severity of an established diagnosis.

Table 3. Conditions requiring increased clinical care

	Routine clinical care NOT CODED	Significant clinical care CODED
Condition managed by nursing or allied health	**Examples of conditions managed with routine nursing and allied health care:** • Nursing incontinence management, pressure area prevention; • Midwifery postpartum breastfeeding/attachment education; • Physiotherapy postpartum rectus abdominis diastasis (RAD) routine assessment and exercise education, without care plan for ongoing management during the episode; • Routine allied health review/assessment of a pre-existing condition, without documented care plan e.g. routine physiotherapy review of Parkinson's patient without a documented care plan.	**Examples of conditions managed with nursing or allied health care, in excess of routine:** • Review of urine incontinence by Incontinence nurse; • One-on-one nurse observation of patient with delirium; • Lactation consultant asked to review patient with cracked nipple, with documentation of a clinical assessment, a diagnostic statement, or a care plan (the care plan may simply be to continue current care already in place by midwifery); • Swallow assessment by Speech Pathologist with documented diagnosis of dysphagia, with commencement of care plan.
Condition managed by medical staff	**Clinical consultation as part of a routine review** (e.g. admission review, ward round review) where a 'clinical assessment' is documented or 'diagnostic statement' made, **without** associated: • therapeutic intervention; or • care plan documented; or • diagnostic procedure requested to establish a diagnosis or provide specificity (including severity) to an established diagnosis.	**Condition specifically receiving 'clinical consultation' with** documentation of a clinical assessment, a diagnostic statement, or a care plan for the condition, meets the *Increased clinical care* criterion. 'Clinical consultation' includes: • Non-routine review e.g. seen by Drug/Alcohol clinician; • Clinician/team asked to see patient ("ATSP"), or provide an opinion (e.g. review by another team); • Referral to a medical specialist, nurse specialist or allied health professional; • Telephone or Telehealth clinical consultation (with documentation of the information exchange).
Condition requiring therapeutic intervention	Refer to: *Routine therapeutic treatment* in Table 1.	**Performance of a therapeutic intervention.** Refer also to: *Significant therapeutic treatment* in Table 1. Examples: • Medical or surgical procedure; • Medication commencement (except for minor/trivial/transient symptoms/conditions– see *Routine therapeutic treatment* in Table 1); • Alteration or adjustment of therapeutic treatment e.g. medication increase or decrease; • When withholding medication for pre-existing condition for treatment of another condition, the pre-existing condition is not coded. For example, aspirin-induced duodenal ulcer with plan to withhold aspirin (patient on aspirin for atrial fibrillation) – code only duodenal ulcer; • Commencement of a care plan (including plan to monitor). For example documented plan for contact precautions and single room isolation for MRSA.

Example 1: In a delivery episode, patient diagnosed with nipple graze by midwife. Regular checks of attachment to ensure correct attachment, with ongoing education. Midwife gave patient Lansinoh cream to apply to graze.

10th Edition	**11th Edition**
O80-O84 and Z37.0 O92.20 *Other and unspecified disorders of breast associated with childbirth, without mention of attachment difficulty* Inconsistent assignment of O92.20 due to inconsistent interpretation between coders about whether Lansinoh cream and/or attachment education meets ACS 0002 criterion 'Increased clinical care'.	O80-O84 and Z37.0 Nipple graze does not meet *Increased clinical care/Conditions are significant/performance of a therapeutic intervention* because Lansinoh cream is a nurse-initiated medication – see *Commencement, alteration of adjustment of therapeutic treatment* which instructs that nurse-initiated medication or nurse-initiated interventions alone are not coded. As per *Increased clinical care/Conditions are not significant*, midwife education for breast feeding attachment is routine postpartum care.

Example 2: In a delivery episode, patient diagnosed with nipple grazes by midwife. Despite ongoing assistance and education from midwives, there was continued attachment difficulty. Patient referred to Lactation Consultant who documented a clinical assessment confirming nipple graze with attachment difficulty, with decision to continue current management.

10th Edition	**11th Edition**
O80-O84 and Z37.0 O92.21 *Other and unspecified disorders of breast associated with childbirth, with mention of attachment difficulty* Referral to/review by Lactation Consultant meets ACS 0002 criterion 'increased clinical care'.	O80-O84 and Z37.0 O92.21 *Other and unspecified disorders of breast associated with childbirth, with mention of attachment difficulty* 95550-16 *Allied health intervention, lactation consultant* As per *Increased clinical care/Conditions are significant*, patient required clinical consultation specifically for nipple graze, with documentation of a clinical assessment (with or without: diagnostic statement or care plan) by the Lactation Consultant. Note: a new ACHI code has been created for Lactation Consultant.

Example 3: Patient admitted for treatment of lower respiratory tract infection. Patient is already on Enoxaparin for atrial fibrillation. During the episode, medical officer diagnosed thrombocytopenia and ordered Enoxaparin be withheld.

10th Edition	**11th Edition**
J22 Unspecified acute lower respiratory infection I48.9 Atrial fibrillation and atrial flutter, unspecified D69.6 Thrombocytopenia, unspecified As per ACCD Coding Rule Q3017 *ACS 0002 Additional diagnoses and alteration to treatment – Part 2* (effective 1 Apr 2016 to 30 jun 2019), although alteration to medication may be related to management of another condition, the therapeutic treatment of the original condition is still being altered and so meets ACS 0002 criterion: commencement, **alteration** or adjustment of therapeutic treatment. Inconsistent assignment of Z92.1 ACS 0303 *Abnormal coagulation profile due to anticoagulants* does not clearly instruct whether it is warranted.	J22 Unspecified acute lower respiratory infection D69.6 Thrombocytopenia, unspecified Z92.1 Personal history of long term (current) use of anticoagulants Thrombocytopenia meets criteria for coding as there was therapeutic intervention (medication withheld) as per *Increased clinical care/Conditions are significant/Performance of a therapeutic intervention.* As per *Commencement, alteration or adjustment of therapeutic treatment,* do not assign an additional diagnosis code for a pre-existing condition where the ongoing medication is adjusted due to management of another condition. Z92.1 is assigned as anticoagulant therapy is withheld because the patient has a medical condition that contraindicates use, as instructed in ACS 0303 *Abnormal coagulation profile due to anticoagulants.*

Example 4

Patient admitted for treatment of depression. The admitting medical officer documents: Plan: 15 minute nursing checks for first 3 days for suicidal ideation.

10th Edition	**11th Edition**
F32.90 Depressive episode, unspecified, not specified as arising in the postnatal period. R45.81 Suicidal ideation Increased nursing care required for suicidal ideation meets ACS 0002 *Additional diagnoses* criterion: Increased clinical care and/or monitoring.	F32.90 Depressive episode, unspecified, not specified as arising in the postnatal period. R45.81 Suicidal ideation Observation in excess of routine care meets ACS 0002 *Additional diagnoses/Increased clinical care/Conditions are significant/Providing care for a condition that is in excess of the routine care.* A plan to perform increased observations is considered a 'care plan' and therefore meets ACS 0002 *Additional diagnoses/Increased clinical care/Conditions are significant/Performance of a therapeutic intervention.*

Example 5: Patient admitted for right hip replacement due to osteoarthritis. Patient has a history of deep vein thrombosis. No further instructions.

10th Edition		**11th Edition**
M16.1	Other primary coxarthrosis	M16.1 Other primary coxarthrosis Z86.72 *Personal history of thrombosis and embolism* is not assigned as it is not relevant as per ACS 0002 *Additional diagnoses, personal history* section.

Example 6: Patient admitted for right hip replacement due to osteoarthritis. Patient on long term anticoagulants due to a history of deep vein thrombosis. INR monitored during the episode.

10th Edition		**11th Edition**
M16.1 Z92.1	Other primary coxarthrosis Personal history of long term (current) use of anticoagulants	M16.1 Other primary coxarthrosis Z92.1 Personal history of long term (current) use of anticoagulants Z92.1 is assigned as per ACS 0303 A*bnormal coagulation profile due to anticoagulants* Z86.72 *Personal history of thrombosis and embolism* and Z92.1 are mutually exclusive as demonstrated by the Excludes note at Z86.72.

Example 7

Patient admitted for COPD and also has uncomplicated Type 2 diabetes. During the episode, patient complains of feeling light headed. Nurse checks BSL which is 3.5mmol/L. Nurse gives patient Carbotest for documented hypoglycaemia and BSL check 15 minutes later is in the normal range. No medical officer or Diabetic Educator consultation required for hypoglycaemic episode, and the patient's BSLs are normal for the remainder of the episode.

10th Edition		**11th Edition**	
J44.9	Chronic obstructive pulmonary disease	J44.9	Chronic obstructive pulmonary disease
E11.64	Type 2 diabetes with hypoglycaemia	E11.9	Type 2 diabetes without complication
Inconsistent assignment of either E11.64 or E11.9 due to inconsistent interpretation between coders about whether nurse initiated interventions for hypoglycaemia meet ACS 0002 criterion 'Increased clinical care'.		Blood sugar level monitoring and management is within the scope of nursing practice. Diabetes is always coded when documented, as per ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia.* Nurse initiated medication or intervention **alone** (without subsequent assessment by clinician/team with diagnostic procedure, therapeutic intervention or care plan commenced, does not meet ACS 0002 *Additional diagnoses/Commencement, alteration or adjustment of therapeutic treatment.* Because hypoglycaemia does not meet criteria for coding it should not be coded as a complication of diabetes.	

Western Australian interpretation of ACS 0002 - suggested changes

Some sections of ACS 0002 have raised uncertainty and will be queried nationally. The suggested amendments (in red font) represent the WA interpretation and will be sent to IHPA seeking clarification of their accuracy.

EXAMPLE 9

A 61-year-old man with a history of hypertension and CKD was admitted with a NSTEMI and acute pulmonary oedema. Patient was treated with BiPAP, GTN infusion and underwent preparation for a coronary angiogram. Prior to the intervention, a renal physician was consulted regarding the patient's kidney function and noted that "Creatinine 140 and eGFR 45. Risk of contrast nephropathy is relatively low given eGFR is more than 30. Patient needs to be monitored for fluid status and UEC, suggest pre and post intervention hydration".

Principal diagnosis:	Non-ST elevation myocardial infarction
Additional diagnosis:	Left ventricular failure
	Chronic kidney disease, stage 3

In this example, the pre-existing CKD meets the criteria in ACS 0002 in the episode of care, as clinical consultation was undertaken with a documented clinical assessment and a care plan for the CKD. Assign U82.3 *Hypertension* (see ACS 0003 *Supplementary codes for chronic conditions*).

EXAMPLE 12:

An 84-year-old female was admitted after a fall. CT scan of head, neck and chest revealed multiple fractures of ribs (4-7) on the left side of chest, which were treated conservatively. Her past medical history included ischaemic heart disease, hypertension, COPD and falls. On arrival, the patient was examined by the ward nurse, who diagnosed and documented a stage I pressure injury (PI) on the left heel. A wound care treatment plan was commenced.

Principal diagnosis:	Fractures of multiple ribs
Additional diagnosis:	External cause of injury
	Place of occurrence
	Activity
	Pressure injury, stage I, heel

In this example the PI was assessed and diagnosed by a nurse (which is within the scope of nursing practice). The pressure injury meets criteria in ACS 0002 as a wound care treatment plan was commenced (*Increased clinical care/Conditions are significant/Performance of a therapeutic intervention*).

Assign U82.3 *Hypertension*, U82.1 *Ischaemic heart disease* and U83.2 *Chronic obstructive pulmonary disease* (see also ACS 0003 *Supplementary codes for chronic conditions).*

COMMENCEMENT, ALTERATION OR ADJUSTMENT OF THERAPEUTIC TREATMENT

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- Do not assign an additional diagnosis code for a condition that is treated with nurse-initiated medications, or nurse-initiated interventions alone (e.g. applying zinc oxide cream for nappy rash; applying Sudocream for groin excoriation; providing a heat pack for neck pain; giving juice or fruit for hypoglycaemia)(See Examples 11,17 & 19)

  An additional diagnosis code can be assigned for the above scenario if a condition is subsequently assessed by a clinician/team, and diagnostic or therapeutic intervention(s) performed, or a care plan is commenced for a condition ~~(see Example 12)~~.

INCREASED CLINICAL CARE

…

- Performance of a therapeutic intervention for a condition (eg dialysis for end-stage renal failure, pharmacotherapy for multiple sclerosis) (see Examples 4, 5, 6, 7 & 12).

EXAMPLE 14

An elderly patient was admitted with per rectal bleeding. A diagnostic sigmoidoscopy was performed, which confirmed rectal cancer. On admission, routine blood tests showed that the patient's haemoglobin level was 79/gL. Day 2 progress notes stated "Hb 79, anaemia is likely due to low gastrointestinal bleeding, repeat FBC, EUC for next two days".

Principal diagnosis: Rectal cancer
Additional diagnosis: Anaemia secondary to blood loss

In this example, the repeat FBC (including Hb) was specifically ordered by a clinician to add specificity to the established diagnosis of anaemia (check if worsening severity). Therefore the anaemia meets the criteria in ACS 0002 in this episode of care.

Acknowledgement

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Supporting information

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