




*ACS 0002 Additional diagnoses
and
ACS 0010 Clinical documentation,
abstraction
and the entire clinical record*


September 2019:
Slide 16: amended to remove ACHI code 96255-00
Slide 18: amended to remove ICD code F03

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ACS 0002 Additional diagnoses


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ACS 0002 Additional Diagnoses

Background:

The objective of reviewing ACS 0002 was not to change the intent of ACS 0002 but to clarify the three criteria for classification purposes, and to prevent the coding of insignificant conditions.




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ACS 0002 Additional Diagnoses

National Minimum Data Set (NMDS)

- As per the AIHW definition of additional diagnoses, the NMDS is not a population health data collection
- Conditions that do not meet ACS 0002 should not be reported as part of the NMDS.
- A jurisdiction can have their own data collections for their own research and population health purposes.




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ACS 0002 Additional Diagnoses

Summary of changes:

1. Clarification of which additional diagnoses should be coded:
 - commencement, alteration or adjustment of therapeutic treatment
 - diagnostic procedures
 - increased clinical care ~~and/or monitoring~~
2. Retirement of redundant ACS:
 - ACS 1336 *Hypertonia*
 - ACS 1342 *Hyperreflexia*
 - ACS 1808 *Incontinence*
 - ACS 2112 *Personal history*




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ACS 0002 Additional Diagnoses

Summary of changes (continued):

3. Clarification of what constitutes a clinical consultation: a clinician/team responsible for managing the patient's condition, a specialist who provides advice/an opinion, nurses, midwives and allied health professionals who engage with the patient.
4. Documentation of the clinical consultation is considered to be any record of the exchange between the patient and the healthcare provider. If the consultation takes place via the phone this exchange must be clearly documented in the clinical record in accordance with the hospital's policy / guidelines.



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ACS 0002 Additional Diagnoses


Why remove 'and/or monitoring' ?

It is a broad statement, and potentially covers many conditions that are only monitored with **no significant impact** on the episode of care. This may include coding of new conditions, pre-existing (chronic) conditions and symptoms for which:

- routine swabs or diagnostic tests are performed
- routine care is provided
- ongoing medications are continued
- routine services provided by clinicians




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ACS 0002 Additional Diagnoses

When NOT to assign a code for an additional diagnosis:

- For transient conditions treated during an episode of care which do not require further consultation e.g Mylanta given for heartburn
- For pre-existing conditions requiring administration of ongoing medication including dose changes, due to the management of another condition eg reducing dose of antihypertensive medication due to hypotension
- For conditions which are treated with nurse initiated medications or interventions
- For routine laboratory investigations



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ACS 0002 Additional Diagnoses


Example:

A 74 year old female was admitted with aspiration pneumonia. Patient had a long history of urinary incontinence. During the admission, her incontinence pads were changed regularly and barrier cream applied daily to the skin by the nurse.

Principal diagnosis: aspiration pneumonia




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ACS 0002 Additional Diagnoses

Conditions are not significant for routine care provided such as:

- General nursing care: administration of medications, dietary checks, recording fluid balance, managing incontinence, pressure sore prevention, assistance with activities of daily living and mobilisation.
- Assessment of vital signs (including pulse, blood pressure, temperature and oxygen saturation, blood glucose levels (BGLs), electrolyte balance, haemoglobin levels and routine functional tests (eg liver and kidney function))



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ACS 0002 Additional Diagnoses


Conditions are not significant for routine care provided such as:

- Assessment of pre-existing conditions where there is no care plan for these conditions
- Pre and post operative management

Care should be taken when assigning additional diagnoses codes for signs and symptoms from Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings as additional diagnoses*.



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ACS 0002 Additional Diagnoses


A number of general and speciality standards direct coders to assign additional diagnosis codes for certain conditions or statuses that do not normally meet the criteria in ACS 0002 *Additional diagnoses*.

Examples of conditions requiring mandatory code assignment as additional diagnoses:

- HIV/AIDS
- Viral hepatitis
- Diabetes mellitus and intermediate hyperglycaemia
- Tobacco use disorders
- Personal history (where appropriate to the episode of care)
- Supplementary codes for chronic conditions



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ACS 0002 Additional Diagnoses

Example:

A 90 year old male was admitted following a fall in the shower at home. Patient sustained a superficial laceration to the scalp, a fractured sternum and subdural haematoma. Chronic conditions for which the patient is on long term medication for include:

Condition	Medication
Atrial Fibrillation	Digoxin 25mg orally once daily
Diabetes Mellitus Type 2	Metformin 500mg orally once daily
GORD	Zantac 150mg orally once daily
Depression	Zoloft 100mg orally once daily
Constipation	Coloxyl and Senna one tablet daily



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ACS 0002 Additional Diagnoses

Episode of care:

Day 2	Patient states hearing loud noises and unable to settle to sleep. Patient experiencing delusions and insisting to get up and go home. Mild sedative prescribed.
Day 4	Patient complaining of increased generalised pain with a score of 9/10. Endone was being given from Day 1 for pain relief, dose was increased on Day 4. Nursing team also advised to continue with mild sedative one hour before sleep.
Day 12	Worsening constipation due to immobility, characterized by lower abdominal cramps. Patient given 2 tablets of Coloxyl and Senna.
Day 17	Patient developed a fever and was given Nurofen. Urine test done to check for UTI. UTI due to E.coli was confirmed. Patient commenced on IV antibiotics.
Day 25	Patient developed stage 1 pressure injury of the sacrum. A wound care treatment plan was commenced.
Day 31	Patient transferred to rehabilitation ward for ongoing care.



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ACS 0002 Additional Diagnoses

Assign:

- S06.5 *Subdural haematoma*
- S01.0 *Open wound of scalp*
- S22.2 *Fracture of sternum*
- W18.2 *Fall in or into bath-tub or shower*
- Y92.03 *Bathroom*
- U73.2 *While resting, sleeping, eating or engaging in other vital activities*
- E11.9 *Type 2 diabetes mellitus without complication*

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ACS 0002 Additional Diagnoses


Assign codes continued:

- K59.0 *Constipation*
- N39.0 *Urinary tract infection, site not specified*
- B96.2 *Escherichia coli [E. coli] as the cause of diseases classified to other chapters*
- L89.04 *Pressure injury, stage I, lower back*

~~96255-00 [1601] Wound management NEC~~

September 2019:
Slide 16: amended to
remove ACHI code 96255-00


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ACS 0002 Additional Diagnoses

Example:

A 74 year old female was admitted with a fractured NOF due to a trip on an uneven footpath, which was managed conservatively. The patient also had demonstrable delirium on a background of dementia, which resulted in the patient trying to repeatedly mobilise from the bed. A one-on-one nurse was required to prevent the patient from climbing over the bed rails and mobilising.



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ACS 0002 Additional Diagnoses


Assign:

S72.00	<i>Fracture of neck of femur, part unspecified</i>
W01.1	<i>Fall on same level from tripping</i>
Y92.41	<i>Sidewalk</i>
U73.9	<i>Unspecified activity</i>
F05.1	<i>Delirium superimposed on dementia</i>
F03	<i>Unspecified dementia</i>

September 2019:
 Slide 18: amended to
 remove ICD code F03




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ACS 0002 Additional Diagnoses

Example:

A 92 year old male was admitted for phacoemulsification of a cataract with IOL. The patient has known Alzheimer's disease and hypertension. The cataract intervention was completed under sedation, with no complications.



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ACS 0002 Additional Diagnoses

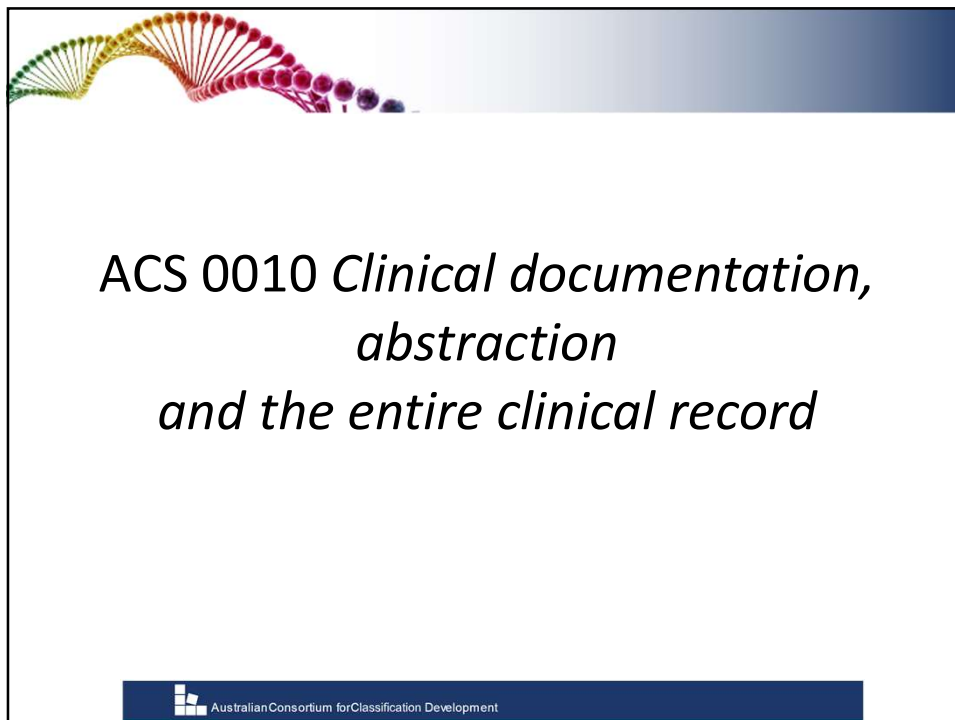
Assign:

H26.9 *Cataract, unspecified*
U79.1 *Dementia (including in Alzheimer's disease)*
U82.3 *Hypertension*

42698-07 [200] *Phacoemulsification of crystalline lens*
42701-00 [193] *Insertion of intraocular lens*
92515-99 [1910] *Sedation, ASA 99*



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ACS 0010 *Clinical documentation, abstraction and the entire clinical record*



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This slide is similar to the first one but includes additional content. The title is at the top right, partially overlapping the DNA graphic. Below the title, the word 'Background:' is followed by a paragraph and a bulleted list. The footer is identical to the first slide.

ACS 0010 *Clinical documentation, abstraction and the entire clinical record*


Background:

Changes to this ACS have come about as a result of:

- emerging issues with documentation contained within an electronic health record (EHR);
- the change to the definition of the 'entire clinical record' in an electronic health environment; and
- the emergence of the role of the Clinical Documentation Improvement Specialist (CDIS)




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ACS 0010

Summary of changes:

1. Guidelines in the use of ICD-10-AM andACHI have been revised
2. Changes to the definition of a health care record
3. New section added consisting of a set of guidelines for generating appropriate classification related queries to clinicians
4. Further information has been added to 'Test results and medication charts'




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ACS 0010

Applying the documentation in the health care record

- Clinical documentation of accurate diagnoses is the responsibility of the clinician.
- Clear and accurate clinical documentation is critical to the continuity, and quality of patient care, and patient safety, and is the legal record of a patient's episode of care.
- Conditions identified from review of past admissions should not be assigned codes, unless these conditions are documented in the current episode of care.




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ACS 0010

Applying the documentation in the health care record

- In an electronic environment where clinical records pertaining to the current episode of care are stored electronically, access to all systems is critical to ensure accurate coding decisions are made
- Where there is ambiguity, or a lack of enough information to enable a sound classification decision to be made, seek information from further sources such as past admissions, referral letters, specialist referral letters, emergency notes, outpatient notes.

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ACS 0010

Generating queries to seek clarification from the clinician

Accurate classification relies on documentation and communication between the clinician and the clinical coder.

Coding queries can be generated and sent to the clinician to help clarify existing documentation.


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ACS 0010

Roles and Responsibilities

Clinician	Clinical Coder
Provides a complete and accurate clinical record of all pertinent diagnoses and procedures on the front sheet and/or discharge summary	Abstracts and extrapolates existing clinical documentation, verifies the information on the front sheet against the health care record for that episode of care
Receives and answers the query and makes relevant updates and/or changes to the health care record	Generates queries due to a lack of adequate information or information which is not clear

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ACS 0010

Guidelines for generating coding queries to clinicians

WHAT?

- Queries should include information about the patient, and reference the documentation and data in question
- Multiple choice answers are an acceptable query format, however this format should be avoided when determining a new diagnosis.
- Queries should not include leading questions which instruct or indicate to a clinician how to respond
- Queries should not reference any information about DRGs / financial / casemix costing

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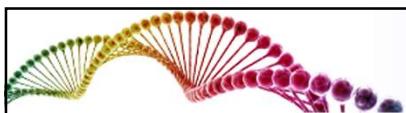
ACS 0010

Guidelines for generating coding queries to clinicians

WHEN?

- Information is ambiguous, conflicting, illegible or incomplete
- Information contained in the record is unclear for condition onset flag assignment
- Findings of investigations recorded without a definitive relationship to a diagnosis
- There is a discrepancy between investigation results and clinical documentation
- Diagnoses recorded on the front sheet and/or discharge summary cannot be substantiated within the current episode of care


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HOW?

- Queries can be sent out manually, electronically, verbally, via email, telephone, fax, telehealth chat.
- A record of the query must be created by the enquiring clinical coder
- It is the coder's responsibility to track the query till resolution and ensure that the query response is maintained in the patient's record.
- The coder should also follow up to ensure that any required updates to the record are made by the clinician as part of the query resolution process.

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Test results and medication charts: shorthand text

Information from test results and medication charts requires careful consideration. Information recorded in shorthand should not be used standalone for code assignment. This includes test result values, descriptions, medication charts, symbols and abbreviations.

All shorthand information must be verified in the body of the current episode of care in order for a code to be assigned.



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ACS 0010


Test results and medication charts: shorthand text

Where shorthand has been used to document/describe a condition, a code may be assigned only if:

- test results (pathology report) verify that a result is abnormal
AND
- there is appropriate ICD-10-AM indexing
AND
- it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.



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Documentation Query

RE: UR:
Admission:
Name:
(Affix label)

Dear Dr

This patient underwent division of adhesions during their Ventral Hernia repair.

Please clarify the underlying reason for the adhesions? (confirmed or suspected):

✗

☐ Due to previous surgery
☐ Due to past infection
☐ Other (please provide details)
☐ Unable to determine

Multiple choice can be leading the clinician. Be careful of the format of your query

If due to previous surgery, please specify the surgery:

Details / further comments:

Signed: _____ Designation: _____ Date: _____



Thank you for taking the time to clarify the treatment that was provided to your patient.

Clinical coder / Health Information Manager-

Fax: _____

Date: _____

To verify integrity of data via clinician's signature and date






ACS 0010 Clinical documentation, abstraction and the entire clinical record

Summary

The Eleventh Edition amendments to ACS 0002 and ACS 0010:


- will decrease the amount of time clinical coders require to search for evidence to determine if a condition meets the criteria in ACS 0002
- will protect the integrity of the NMDS and support clinical coders in their workplace
- prompts health care facilities to ensure that they have infrastructures in place to improve clinical documentation and ultimately facilitate consistent and accurate coded clinical data

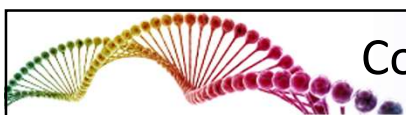

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Further Information

For further detailed information regarding this revision please refer to the Reference to Changes Document provided in this Education Package.

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