



IHACPA

## Implementation of cluster coding – Frequently Asked Questions (FAQs)

### 1. What is a diagnosis cluster identifier (DCID)?

A diagnosis cluster identifier (DCID) is an alphanumeric character allocated to each ICD-10-AM code reported within an episode of care to identify and maintain the link between diagnosis codes as the data is collected, validated, processed and analysed.

### 2. What is the difference between cluster coding and a diagnosis cluster identifier (DCID)?

The process of allocating DCIDs to codes within admitted episodes of care is known as cluster coding.

### 3. Where can metadata for cluster coding be found?

The [Metadata Online Registry \(METEOR\)](#) is the data repository for health data standards. Data items, attributes and guidelines for collection and reporting can be found through the search function.

### 4. Has an Australian Coding Standard (ACS) been created to provide guidelines on the allocation of the diagnosis cluster identifier (DCID)?

Yes. ACS 0004 *Diagnosis cluster identifier (DCID)* has been created for ICD-10-AM/ACHI/ACS Thirteenth Edition.

### 5. When will cluster coding be implemented?

Cluster coding will be implemented from 1 July 2025 with ICD-10-AM/ACHI/ACS Thirteenth Edition.

IHACPA recommends jurisdictions implement ACS 0004 from 1 July 2025 even if the ability to report the DCID has not been fully implemented.

As soon as clinical coding software systems allow for allocation of the DCID, the clinical coder is able to apply ACS 0004 and a hospital/jurisdiction can commence cluster coding. Many health information systems are involved in the journey of the coded data from the point of collection (by the clinical coder) through to the systems for national reporting. The provision of supplementary value '9' supports a period of transition until all systems are updated to report the DCID.

Cluster coding is proposed to be implemented in a staged approach.

### 6. What is in scope for stage one?

Stage one is outlined in ACS 0004 *Diagnosis cluster identifier (DCID)*. There are two types of clusters:

- **Diagnosis cluster**

A diagnosis cluster includes codes that are assigned with external cause codes (for example injuries, complications, adverse effects, sequelae, other conditions where an external cause code is assigned)

- **Chronic condition cluster**

The chronic condition cluster includes codes from block U78–U88 *Supplementary codes for chronic conditions*, assigned in accordance with ACS 0003 *Supplementary codes for chronic conditions*.

Any diagnosis codes not eligible for a diagnosis cluster or the chronic condition cluster in stage one will be allocated to DCID 8.

**7. What is in scope for stage two and when will stage two be implemented?**

Any decision on expansion of cluster coding will be made in consultation with stakeholders and implemented with a new edition of ICD-10-AM/ACHI/ACS.

**8. How often will the DCID field need to be updated in health information systems?**

The DCID data item has been designed to accommodate future expansions of ACS 0004 *Diagnosis cluster identifier (DCID)*. Any progression from stage one to stage two will happen through amendments to ACS 0004, and potential changes to edit values in the ICD-10-AM Electronic Code List (ECL). Amendments to the DCID field and data collections will not be required.

**9. Can additional chapter codes be allocated to a cluster, such as B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters*?**

Yes, where they are relevant to the cluster (such as a postoperative wound infection) additional codes may be allocated to a diagnosis cluster.

**10. What type of administrative codes can be clustered?**

Codes from Chapter 21 *Factors influencing health status and contact with health services (Z00–Z99)* may be included where they are related to the diagnosis cluster.

**11. Can codes within a cluster have different condition onset flag (COF) values?**

Codes within a cluster may have different COF values where appropriate, allocated in accordance with ACS 0048 *Condition onset flag*.

**12. Are dagger/asterisk codes or cancer/morphology codes clustered?**

No, dagger and asterisk, and cancer and morphology codes do not form a diagnosis cluster of their own in stage one. However, there is nothing preventing one of these codes from being included in a diagnosis cluster where they meet the guidelines in ACS 0004.

**13. Are ACHI codes allocated to clusters?**

No, ACHI codes are not allocated to clusters. Only ICD-10-AM codes can be allocated DCID values.

**14. How do the new rules for double coding work?**

ACS 0004 allows double coding of codes from Chapter 19 *Injury, poisoning and certain other consequences of external causes (S00–T98)* and Chapter 20 *External causes of morbidity and mortality (U50–U73, V00–Y98)* **only** where the same code is allocated in separate diagnosis clusters in an episode of care.

Diagnosis codes from Chapters 19 and 20 cannot be duplicated within a diagnosis cluster.

Diagnosis codes from Chapters 1–18 and 21 cannot be duplicated within an episode of care.

**15. Are there any impacts on Australian Refined Diagnosis Related Groups (AR-DRG) assignment?**

There will be no impact on AR-DRG assignment. The AR-DRG grouper eliminates duplicate ICD-10-AM codes, therefore clustering has no impact on AR-DRG assignment.

**16. Do DCIDs need to stay in order?**

No. Where a diagnosis cluster includes the principal diagnosis, this must be allocated DCID A (Cluster A). After that sequential alphabetic DCID values must be allocated (that is DCID B, C, D, and so forth through to Z, and then AA, AB through to ZZ if required). However, if codes within an episode are resequenced, it is not necessary that Cluster B remains sequenced before Cluster C.

**17. Can I skip a DCID value?**

No.

## 18. Will there be an impact on Hospital Acquired Complications (HACs)?

The allocation of a DCID value will more precisely identify relationships between codes and events. Therefore, IHACPA anticipates that cluster coding will more accurately reflect HACs, once they have been integrated into the HAC design logic.

## 19. Is there a limit on how many codes can be allocated to a single cluster?

No, there is no limit. For example, in the event of a multiple trauma accident, assign as many codes as required and allocate the same DCID value to all ICD-10-AM codes within the cluster (see ACS 1907 *Multiple injuries*).

## 20. Given that double coding of some ICD-10-AM codes is now allowed, how should code assignment be prioritised when there is a limit on number of codes able to be reported for example, limit of 40 diagnosis codes?

For national reporting, both the Admitted Patient Care National Minimum Data Set (APC NMDS) and the APC NMDS Data Request Specification (DRS) have facility to report and receive up to 100 diagnosis codes. Limits of lower than 100 diagnosis codes are set at a jurisdictional level.

Clinical coders will still need to prioritise the most significant conditions as per current practice.

## 21. Why are supplementary codes for chronic conditions clustered since they are already sequenced at the end anyway?

The data collections for admitted patient care have evolved over decades to capture additional information to further contextualise hospital activity, including the condition onset flag in 2008 and the introduction of the supplementary codes for chronic conditions in 2015.

A staged approach builds familiarity and allows time for health services and the clinical coding workforce to prepare for a broader implementation of what is clustered. In stage 2, consideration may be given to replacing the limited subset of codes in category U78–U88 *Supplementary codes for chronic conditions* with their chapter code equivalent, thereby adding specificity and minimising the need for mapping and duplication in the classification.

## 22. How will the DCID work in ICD-11?

The DCID has been designed to align with ICD-11 reporting requirements, therefore establishing the data element will support interoperability between ICD-10-AM and ICD-11. The conceptual model for linking related codes in ICD-10-AM aligns with the principles for clustering in ICD-11, known as post coordination.

It is anticipated that the investment required in the initial implementation of the DCID will not require duplication in a potential implementation of ICD-11.

## 23. Will there be validation rules to assist with edits?

A new field, 'Cluster allocation required', has been included in the ECL, with 3 values:

- **ECL value 0 – cluster allocation not required**

This value will be applied to all ICD-10-AM codes not identified as ECL value 1 or 2.

While these codes will not usually be allocated to a cluster, they are not precluded from being in a diagnosis cluster if appropriate for the episode, such as adverse effects, procedural complications and infections. For example:

- N20.0 *Calculus of kidney (ACS 0102 HIV/AIDS)*
- K29.70 *Gastritis, unspecified, without mention of haemorrhage (ACS 1902 Adverse effects)*
- Z14.02 *Resistance to beta-lactamase resistant [second generation] penicillins (ACS 0112 Infection with drug resistant microorganisms)*

- **ECL value 1 – cluster allocation required**

These codes must be in either a diagnosis cluster or the chronic condition cluster, and include:

- all codes in Chapter 19 – the injury and poisoning codes
- all codes in Chapter 20 – the external cause codes themselves
- all codes in block U78-U88 – the supplementary codes for chronic conditions
- other codes which explicitly belong in a cluster, such as end of chapter codes for *Accidental puncture and laceration during a procedure*

- **ECL value 2 – cluster allocation may be required**

These codes have an *Instructional* note in the Tabular List about assigning external cause codes. For example, this includes:

- Block B15-B19 *Viral hepatitis*
- Code D89.3 *Immune reconstitution syndrome*
- Category D89.8 *Other specified disorders involving the immune mechanism, not elsewhere classified.*

#### **24. What are the characteristics of the METEOR data item?**

The METEOR data item is a String data type, with a format of X[X] alphanumeric characters, and a maximum character length of 2. Finalised details will be integrated into the APC NMDS DRS.

#### **25. The METEOR data item includes supplementary value DCID 9 *Not reported*, but this is not mentioned in ACS 0004. How will DCID 9 be allocated?**

Implementation of cluster coding may take time for all the necessary systems to be updated. During implementation, some systems may be ready before others.

DCID 9 is provided for health information system use. Where a receiving system requires a field to be populated but the submitter/user is not collecting DCID values, DCID 9 is to be used.

For example, there will be instances where a data repository can collect values, but the submitting system (for example, a hospital patient administration system) cannot allocate values. In this case, the receiving system will be able to populate DCID 9 into the empty field for reporting purposes.

Therefore, DCID 9 needs to be available within all health information software systems and will be included in IHACPA's 2025-26 APC NMDS DRS.

This value is not intended to be available to clinical coders to use and is therefore not referenced in ACS 0004.

#### **26. What about DCID 1-7?**

DCID 1-7 are being included for future proofing, in case of unknown factors.

This is a similar approach to that adopted for the introduction of placeholder codes.

These values are reserved and may only be allocated upon instruction from IHACPA.

#### **27. Are there any impacts on the Frailty Related Index of Comorbidities (FRIC) score?**

For the purposes of FRIC in AN-SNAP V5.0 if an in-scope code is assigned more than once it will only be counted once. This aligns with the context in which AN-SNAP V5.0 was designed to be implemented.