Eleventh Edition ICD-10-AM/ACHI/ACS Victorian education

Updated for ACS 0002 Additional diagnoses effective1 January 2020

Introduction

The Eleventh Edition Victorian education originally published in September 2019 is intended to supplement the Eleventh Edition education published by the Australian Consortium for Classification Development (ACCD) on 16 May 2019, the FAQs published on 15 June 2019 and updated on 28 June 2019 which have been disaggregated and published in the IHPA Australian Classification Exchange (ACE). In some cases, additional instruction is provided where Victoria considers the documents do not provide clarity.

The education has been updated as follows to align with the errata 3 for ACS 0002 Additional diagnoses published by IHPA, effective 1 January 2020:

- Addition of a note to example 7 to advise ACS 0002 is silent on scenarios where the plan of care is not carried out and IHPA advice has been sought
- Removal of references to wound care specialist in examples 20 and 23 and amended note in example 23 that clarifies that a wound specialist or a general nurse may formulate and document a plan to manage the pressure injury
- Under section ACS 0010 Clinical documentation and general abstraction guidelines, the reference to Eleventh Edition FAQs Part 1 has been updated as it has now been incorporated into ACE
- Removal of reference to the Eleventh Edition FAQs – Amended in example 6 as the advice about IM ergometrine was removed by IHPA

The purpose of this education is to ensure consistent application of the Eleventh Edition changes and is applicable in Victoria to separations on or after 1 July 2019. However, there is no expectation that health services and hospitals retrospectively amend their data.

The education does not cover all changes to Eleventh Edition but rather the changes that the Victorian ICD Coding Committee (VICC) identified as areas where clinical coders require further clarification. The education is intended to support Victorian clinical coders to produce coded data that is accurate, complete and reliable for the purposes for which it is required.

From the data quality point of view there is no difference in the significance of the data from private or public organisations. In Victoria, private hospitals are registered contingent upon them, among other things, reporting to the Department of Health and Human Services in accordance with specifications outlined by the department, and to that end, the education contained in this document applies equally to the private sector as to the public sector.

Contents

This document contains Eleventh Edition Victorian education on the following standards and changes:

ACS 0002 Additional diagnoses

Eleventh Edition ACS 0002 states:

For classification purposes, additional diagnoses should be interpreted as conditions that significantly affect patient management in terms of requiring any of the following criteria:

- *commencement, alteration or adjustment of therapeutic treatment*
- *diagnostic procedures*
- *increased clinical care*

These three criteria are not mutually exclusive. Conditions must meet one or more of these criteria.

COMMENCEMENT, ALTERATION OR ADJUSTMENT OF THERAPEUTIC TREATMENT

The first dot point of ACS 0002 under section Commencement, alteration or adjustment of therapeutic treatment states:

Do not assign an additional diagnosis code for a condition that can be treated successfully with administration of medication without the need for further consultation, investigation or a plan of care (e.g. Mylanta for heartburn; paracetamol for headache; Sominex for insomnia; zinc oxide cream for nappy rash; Sudocream for groin excoriation)

When a condition is treated without further consultation, investigation or a plan of care, **do not assign a code for the condition**.

Conditions can be coded when the condition is documented by the treating clinician/team **and** there is documentation of an assessment of the condition **and** a care plan is prescribed.

Where a condition and a treatment plan are documented in the same note in the record, the condition can be coded, provided the treatment plan relates to the condition.

The following are examples where an additional diagnosis code can be assigned for a condition documented as a result of a clinical consultation with a plan of care.

Example 1

Ongoing oxygen requirements due to decreased saturations, evidenced by documentation of clinical consultation by the treating team or with other clinicians.

In this example the decreased oxygen saturations are coded because there is documentation of clinical consultation and a plan for ongoing oxygen.

Example 2

From ICU chart
16/6 1800 – 20mmol KCL
16/6 1900 – 10mmol KCL
16/6 2100 – 10mmol KCL
17/6 0200 – 10mmol KCL
Dr notes on 16/6 2300 – noted blood results: K+ 3.1 -> 4.5 after 40mmol KCL

In this example hypokalaemia is coded (provided test results verify that K+3.1 is abnormal) because there is documentation of low potassium, evidence of therapeutic treatment and assessment by the doctor of the therapeutic treatment.

Example 3

Nurse documents stat dose of magnesium for Mg 0.65 following consultation with a doctor. Doctor has signed off on the magnesium order on the medication chart.

In this example hypomagnesaemia is coded (provided test results verify that Mg 0.65 is abnormal) because there is documentation of low magnesium, the nurse has documented the consultation with the doctor and the doctor has signed off on the stat dose of magnesium.

Example 4

Doctor documents acute pulmonary oedema with a plan for stat Frusemide. Medication chart shows medication given.

In this example APO is coded because there is a diagnosis and the doctor has documented a plan of care which is the stat dose of Frusemide as evidenced in the medication chart.

Example 5

O&G Review
D3 post vacuum & PPH 2.3L, Minimal PV loss
Hb today 84

Plan
- PO Fe and Vit C daily
- IDC out
- Notify if concerns

Nursing am – postnatally well. Hb 84. Ferro-grad and Vit C given as charted.

In this example anaemia is coded (provided test results verify that Hb 84 is abnormal) because the treatment plan of oral iron (Ferro-grad) and Vit C relates to the condition of anaemia (Hb 84) as documented by the clinician.

Example 6

Patient had spontaneous vertex delivery. Midwife documents:
PPH: 800ml – 200mg IM Ergometrine given stat.

Coding of PPH in this example is based on a condition (PPH) being documented with a plan of care (IM Ergometrine) by a clinician (midwife) acting within their scope of practice. That is, there is commencement of therapeutic treatment for a complication of delivery.

Example 7

Patient noted to have low Hb, diagnosed with iron deficiency anaemia – plan iron infusion. Patient declined iron infusion during admission, so none administered.

In this example the iron deficiency anaemia is coded because a plan of care has been prescribed but was not carried out because the patient refused treatment.

NB: ACS 0002 Additional Diagnoses is silent for scenarios where the plan of care is not carried out. However, VICC considers that as a plan of care was prescribed the iron deficiency anaemia still meets ACS 0002 despite the refusal of treatment. This example will be updated when IHPA advice becomes available.

Example 8

Patient with cancer, is reviewed by the oncologist. The oncologist documents the decision to stop treatment because the patient has not responded to treatment as expected. Patient is transferred to palliative care.

In this example the cancer is coded because the treatment for the cancer has been adjusted.

The third dot point under Commencement, alteration or adjustment of therapeutic treatment states:

- *Do not assign an additional diagnosis code for a pre-existing condition that results in minor adjustment to the diagnostic work-up or the care plan (e.g. ordering a non-contrast CT scan instead of a contrast CT scan; a V/Q scan instead of a CTPA for a suspected pulmonary embolism in patients with chronic kidney disease; selection of non-hepatotoxic agents in patients with chronic liver disease)*

  An additional diagnosis code can be assigned for a pre-existing condition if it results in a major variation to the care plan for another condition (e.g. a procedure is delayed/cancelled due to a pre-existing condition; patient needs admission to the Intensive Care Unit following surgery that would normally be managed in the surgical ward postoperatively). See also ACS 0011 Intervention not performed or cancelled

The following examples are intended to assist in the consistent interpretation of these terms major and minor:

Example 9

Patient with atrial fibrillation (AF). Doctor documents that anticoagulant is required, but patient has lung metastases which contraindicates for anticoagulation.

In this example the lung metastases (and primary and any other secondary sites) are coded because the condition results in a major variation in the care plan of the AF (decision not to treat AF). AF is also coded because there is documentation of a care plan for AF.

Example 10

Patient is on methotrexate for pre-existing rheumatoid arthritis (RA). Biochemistry reveals abnormal liver function. Consultation with patient and rheumatologist about the ongoing risk versus benefit of methotrexate for rheumatoid arthritis resulted in a decision to stop methotrexate in order to prevent damage to liver.

In this example, RA is coded because it required clinical consultation about treatment. Abnormal liver function is coded because it has caused a major variation to the treatment of rheumatoid arthritis.

Example 11

Patient is on methotrexate for pre-existing rheumatoid arthritis. The patient has been admitted for treatment of sepsis and chest infection. Methotrexate is contraindicated in infections and was withheld during the admission. Methotrexate recommenced back to the normal dosage on discharge.

In this example, the RA is not coded as the ceasing of the methotrexate was for the infection and when restarted it was recommenced at the same dosage.

Example 12

25-year-old patient documented as requiring general anaesthesia for tooth extraction due to autism.

In this example, autism is coded because it has necessitated an inpatient episode for a procedure that could normally be performed without inpatient admission or general anaesthesia.

Example 13

Patient requires admission the day prior to colonoscopy for staff to administer the bowel preparation because the patient has dementia.

In this example, dementia is coded because it necessitated increased length of stay.

Example 14

Patient admitted for TURP for BPH. Documented that patient needed to be first on theatre list due to a pre-existing anxiety disorder.

In this example the anxiety disorder is not coded because positioning on a theatre list is a minor adjustment of care.

Example 15

Patient requires MRI for headache under sedation because of pre-existing claustrophobia, which would normally be performed without anaesthetic.

In this example claustrophobia is coded because it has resulted in a major variation to the care plan of the headache.

Example 16

Patient admitted with chest pain and dyspnoea found to have lung mass requiring bronchoscopy and lung biopsy for tissue diagnosis. Lung biopsy was not taken due to patient's pre-existing thrombocytopenia.

In this example, thrombocytopenia is coded because it is a pre-existing condition that has resulted in a major variation (lung biopsy not able to be performed) to the care plan of the lung mass.

DIAGNOSTIC PROCEDURES

Eleventh Edition ACS 0002 states:

For classification purposes, do not assign an additional diagnosis code based on the performance of routine tests alone, such as (see Example 13):

- *routine ARO (Antibiotic Resistant Organisms) screening*
- *full blood count (FBC)*
- *functional tests (e.g. liver or kidney function)*

An additional diagnosis code can be assigned for a condition if a diagnostic test(s) was ordered specifically to establish a diagnosis or provide greater specificity to an established diagnosis.

There is no change in the application of the diagnostic procedures section of ACS 0002.

Example 17

Patient is incontinent for eight days, documented in the progress notes and pads changed daily as noted in the nursing care plan. A urinary specimen is taken, and a bladder scan is performed to investigate the incontinence.

In this example incontinence is coded because diagnostic tests were performed specifically for the incontinence.

INCREASED CLINICAL CARE

Eleventh Edition ACS 0002 states:

Conditions are not significant *in an episode of care when clinical care provided for a condition is routine in nature. Examples of routine clinical care include:*

- *general nursing care, such as administration of medications, dietary check, recording of fluid balance (intake and output), management of incontinence (e.g. urinary and bowel), pressure area prevention and skin care, assisting 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 (e.g. liver and kidney function)*
- *assessment of pre-existing conditions without a documented care plan specifically for these conditions (e.g. routine preoperative anaesthetist assessment, routine allied health assessment such as physiotherapy assessment of Parkinson's disease, with no documented care plan or treatment commenced)*
- *pre and postoperative management, such as withholding medications prior to an intervention, checking drain/catheters, monitoring pain levels and bowel function, deep venous thrombosis and pressure injury prophylaxis*

The following examples are intended to further assist in the interpretation of **routine care**:

Example 18

Patient with dementia requires general management including redirection when wandering and assistance with meals.

In this example dementia is not coded as the care provided is routine in nature.

Example 19

Patient admitted with AMI and has Parkinson's disease. Patient requires assistance with ADLs and moving in/from bed.

In this example Parkinson's disease is not coded as the care provided is general nursing care to assist the patient.

Example 20

Patient has new small pressure area on sacrum. Cleaned and dressed. Patient provided with an air mattress.

In this example the small pressure area is not coded because no care plan for the condition is documented; the care provided for the pressure area was a routine intervention.

Conditions are significant *in an episode of care when clinical care provided for a condition is beyond routine (i.e. increased clinical care). Examples of increased clinical care include:*

- *providing care for a condition that is in excess of the routine care that would normally be provided by medical officer/nursing/allied health for that condition (e.g. documented evidence that the patient with dementia requires increased observation due to fluctuation in behaviour, cognition and physical condition)*
- *receiving clinical consultation for a condition with documentation of a clinical assessment, and a diagnosis, and a care plan for the condition (e.g. patient referral to an oncologist for cancer assessment with documentation of advice received; wound specialist/nurse assessment of pressure injury with documentation of staging of pressure injury and care plan). Note that a care plan may include an adjustment to, or continuation of, the current treatment plan, or transfer to another facility with documentation of the reason(s) for transfer*
- *performance of a therapeutic treatment/intervention for a condition (see also ACS 0002 Additional diagnoses/Commencement, alteration or adjustment of therapeutic treatment)*
- *pre and postoperative management in excess of routine care (see also ACS 1904 Procedural complications)*

The following examples are intended to further assist in the interpretation of **increased clinical care**:

Example 21

Patient seen by physiotherapist and occupational therapist for bibasal atelectasis. Plan by the treating allied health team was to have further ongoing OT and PT reviews in order to monitor chest and mobility.

In this example, atelectasis is coded as the patient received clinical consultation with the allied health team for atelectasis, resulting in a documented plan of care.

Example 22

Patient with dementia is wandering extensively. A plan is formulated and documented for 'frequent checks' on the patient.

In this example dementia is coded because the patient requires increased observation.

Example 23

Patient has a new stage 2 pressure injury near sacral region. Aquacel soft is applied and patient is changed to a pressure mattress. A wound management chart is completed detailing a plan for ongoing care with a dressing regime.

In this example the pressure injury is coded because there is documentation of the condition, assessment of the pressure injury and a documented plan of care to support the management of the pressure injury.

Note: A documented plan may be in the progress notes or on a wound management chart. A wound specialist or a general nurse may formulate and document a plan to manage the pressure injury.

Example 24

Physiotherapist diagnoses divarication of rectus abdominis muscles (DRAM) postpartum. The physiotherapist formulates and documents a plan for the patient for exercises to be completed at home to treat DRAM.

In the example DRAM is coded because there is a clinical consultation for the condition with a plan of care.

Note: Physiotherapy attention is often provided routinely post-delivery e.g. in a post-natal check and DRAM may be noted however the exercise regime needs to be linked to the treatment of DRAM.

Example 25

Patient admitted for treatment of a chronic/general medical condition such as COPD also has cancer. The oncologist reviews the patient and documents 'no change to the current treatment'.

In this example, the cancer has received clinical consultation with documentation of a clinical assessment with a plan for continuation of the current treatment plan, therefore the cancer can be coded.

Example 26

Patient with incontinence has an indwelling catheter inserted to manage the incontinence.

In this example incontinence is coded because it is managed by therapeutic treatment/intervention – an indwelling catheter.

Example 27

Patient develops a painful, compressible mass that is red, warm to the touch, and tender on right thigh. Clinician reviews and documents abscess – for incision and drainage. I&D performed the next day.

In this example, the abscess is coded because it is managed by therapeutic treatment/intervention – incision and drainage.

ACS 0010 Clinical documentation and general abstraction guidelines

Eleventh Edition ACS 0010 states:

ROLES AND RESPONSIBILITIES IN THE DOCUMENTATION AND ABSTRACTION PROCESS

Information from the health care record outside of that directly relating to the current episode of care can help to inform code assignment. For example:

- *Past episodes of care (at current or other health facility)*
- *Referral letters and other correspondence*
- *Emergency notes*
- *Outpatient notes*

Such sources can be used to:

- *clarify documentation contained within the current episode of care*
- *gain further specificity on documentation contained within the current episode of care*
- *determine the reason for admission (e.g. reviewing outpatient notes and referral letters).*

Reviewing the entire health care record other than for these reasons is not acceptable classification practice. In addition, information incidentally identified while seeking further clarification and/or specificity for information documented in the current episode of care, or for determining the reason for admission should not be used in code assignment. For example, documentation of ex-smoker in a previous episode or mention of hepatitis C in outpatient notes.

If, after following the above guidelines, the documentation within the health care record is inadequate for complete and accurate classification, the clinical coder should seek information from the clinician.

The instructions above apply to all admitted episodes, including statistical admissions, admissions from the emergency department and transfers from another hospital.

Notwithstanding the advice in the IHPA ACE *Eleventh Edition Education Frequently Asked Questions Part 1 Coding Rules for implementation 1 October 2019* , specialty standards ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* and ACS 0236 *Neoplasm coding and sequencing* should be applied to code the severity of the condition provided diabetes or a neoplasm is documented in the current episode, to maintain consistency of data.

Example 28

Patient presents for treatment of breast cancer, correspondence notes and prior admissions state that the patient has metastases to bone and lymph nodes. Metastatic sites are not documented in the current admission notes.

In this example there is documentation of breast cancer in the current episode of care, so it is appropriate to reference the correspondence or prior admission notes for further specificity of morphology and/or metastatic sites. The bone and lymph node metastases are coded in accordance with ACS 0236 *Neoplasm coding and sequencing* which states ‘Where there are multiple secondary (metastatic) sites, assign a code for each metastatic site to reflect the severity of the neoplastic condition’.

Example 29

Patient with breast cancer presents with CCF. During the episode patient reports hip pain and an x-ray is done which shows bone lesions. The patient is referred to the oncologist who orders a bone scan and bone metastases are diagnosed. The breast cancer histology from a previous episode states it is infiltrating ductal carcinoma of breast with metastases in axillary lymph nodes.

In this example, assign codes for infiltrating ductal carcinoma of breast with bone and lymph node metastases. Lymph node metastases are coded because they are documented and add specificity of severity to the neoplastic condition.

Example 30

Diabetes noted in the progress notes, but no specific diabetic complications/history noted. Patient is a direct admit from ED. ED notes states Type 2 diabetes with retinopathy and current obesity.

In this example there is documentation of DM in the current episode of care, so it is appropriate to reference the ED notes for further specificity of the type of diabetes and the diabetic complications. Codes for Type 2 DM with retinopathy and obesity are assigned in accordance with ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* rule 4a.

Example 31

Type 2 DM documented on the anaesthetic chart of a patient having a same day colonoscopy to investigate PR bleeding. Correspondence states patient has diabetic retinopathy.

In this example, Type 2 DM is documented within the episode of care, so it is appropriate to reference correspondence for further specificity of the severity of diabetes in accordance with ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* rule 4a.

Example 32

Patient presents for treatment of rheumatoid arthritis. Seropositive rheumatoid arthritis is noted in the correspondence.

In this example there is documentation of rheumatoid arthritis in the current episode of care, so it is appropriate to reference the correspondence for further specificity. The seropositive rheumatoid arthritis is coded as the correspondence provides further specificity of the rheumatoid arthritis.

Example 33

Patient is admitted for a total knee replacement for osteoarthritis of the knee. Patient is statistically discharged from the acute episode and admitted to rehabilitation. The reason for rehabilitation is documented as ‘Rehab for TKR’.

In this example it is appropriate to reference the previous episode of care to determine the reason for the TKR which was the reason for admission to rehabilitation; the osteoarthritis of the knee.

Example 34

Patient is transferred from hospital A to hospital B for rehabilitation. Admission notes at hospital B state 'For rehabilitation post THR. Transfer notes from hospital A state 'Admitted to hospital A with OA hip for THR'.

In this example it is appropriate to reference the transfer notes to determine the reason for the THR which was the reason for admission to rehabilitation; the osteoarthritis of the hip.

Example 35

Patient presents to ED, is admitted to the Short Stay Unit and then subsequently transferred to another inpatient ward of the same hospital. ED notes state patient is a smoker, but the smoking status is not documented anywhere in the SSU or admission notes.

In this example smoking status is not coded as it is not documented in the current episode of care, it is considered an incidental finding when referencing documentation outside of the current episode of care.

GUIDELINES FOR GENERATING APPROPRIATE QUERIES TO CLINICIANS

The following points summarise the Eleventh Edition ACS 0010 Clinical documentation and general abstraction guidelines requirements for queries to clinicians:

- The query references the documentation in the record that has prompted the query
- The query enhances the clinical truth of the existing documentation
- The query allows the clinician to add context to their response
- The query is not leading to a particular response
- The query does not indicate potential financial impact (including indication to move from one DRG to another)
- The query is signed, named, dated and designated by the person creating the query
- The query response is signed, named, dated and designated by the person answering the query
- The query is an open or multiple-choice format, except in circumstances where a yes/no format is appropriate

Example 36

Documentation of abdominal adhesions as findings on the operation report and documentation of mobilisation of adhesions performed in the body of the operation report. The MBS item number for division of adhesions is recorded on the operation report.

Can you please clarify whether the adhesions were divided?

Additional comments:

In this example, a multiple choice format is not necessary because the query has been generated to clarify the inconsistent documentation.

Example 37

Principal diagnosis on the discharge summary of 'post-operative PR bleeding'. Documentation of history of haemorrhoidectomy 3 days ago. PR bleeding resolved and patient was discharged home. Could you please clarify whether the post-operative PR bleeding is:

a) Due to the procedure
b) Occurring in the post-operative period but NOT due to the procedure (not a complication)
c) Condition not solely related to the procedure, but related to the complex interaction between the disease process and the procedure (not a complication)
d) Other – please specify
e) Unknown / unable to determine

Additional comments:

In this example, a multiple choice format is used to establish whether there is a causal relationship between the bleeding and the procedure.

Example 38

Documentation that the patient was commenced on CPAP for 5 hours to treat type 2 respiratory failure.

Can you please clarify whether the type 2 respiratory failure can be further specified as:

a) Acute type 2 respiratory failure
b) Chronic type 2 respiratory failure
c) Acute on chronic type 2 respiratory failure
d) Type 2 respiratory failure is the best description
e) Other - please specify
f) Unknown / unable to determine

Additional comments:

In this example, a multiple choice format is used to clarify the acuity of the condition.

Example 39

Documentation on the medication chart that the patient was newly commenced on Nilstat on day 10 and patient continued on this drug for seven days. The indication on the medication chart is oral thrush with no supportive evidence documented in the progress notes. Coding rules state than an indication for treatment only documented on a medication chart is insufficient for coding purposes.

Can you please clarify the reason for the Nilstat treatment?

a) To treat the patient's oral thrush
b) Prophylactic treatment for oral thrush
c) Other - please specify
d) Unknown/unable to determine

Additional comments:

In this example, a multiple choice format is used to clarify the diagnosis.

Example 40

In the progress notes (p2, p4) it is documented that the patient had LRTI requiring commencement of antibiotics however pneumonia is also documented (p1, p5).

Could you please clarify the diagnosis?
a) LRTI
b) Pneumonia
c) Other – please specify
d) Unknown/unable to be determined

Additional comments:

In this example a multiple-choice format has been used to clarify the condition as two different terms are documented.

Example 41

There is no discharge summary for this episode therefore there is no documented principal diagnosis. Progress notes (p1, p2) document reason for admission as LRTI, progress notes (p3, p5) document community acquired pneumonia, and the chest x-ray on day of admission states "consolidation left lower lobe".

Could you please clarify the principal diagnosis for this episode?

Additional comments:

In this example an open-ended question is sufficient to establish the principal diagnosis; a multiple-choice option is not necessary.