Guide to Major Eleventh Edition Changes:

ACS 0010 *Clinical documentation and general abstraction guidelines*

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Contents

Clinical documentation and abstraction

Update to ICD-10-AM, ACHI and ACS, namely ACS 0010 *Clinical documentation and general abstraction guidelines* to address:

- emerging issues in the electronic health record environment;
- emergence of the clinical documentation improvement specialist (CDIS) role; and
- generating appropriate queries to clinicians.

ROLES AND RESPONSIBILITIES

Combined effort between clinician, coder and CDIS
is essential to achieve complete and
accurate documentation and code assignment.

Clinician

Diagnose

Document

Answer queries

It is not the role of the coder (or CDIS) to diagnose.

Responsibility for documentation of accurate diagnoses and interventions lies with the clinician, not the coder (or CDIS). Recording such documentation is limited to designated members of the clinical team.

Coder

Abstract → Verify → Query *if required* → Classify

Definition of current episode of care

A documented account of the patient's inpatient journey from admission (date and time) to discharge (date and time), including, but not limited to: physical examination, history of present illness, past history, health care plan(s), consultations, observations, investigations and evaluations, diagnoses, treatment (including medications), intervention(s), progress and health outcomes.

Abstract from current episode of care

For classification purposes the primary source of information within the health care record is the current episode of care and clinical documentation of the treating medical officer.

Example 1

Patient admitted for treatment of asthma. During the admission patient complained of persistent pain and swelling in their right elbow. A referral was made to an orthopaedist during the admission and the decision made to aspirate the joint in the outpatient clinic before discharge.

The diagnosis and procedure details may be recorded in the outpatient notes however these notes are still considered documentation from the current episode as the referral was generated, consultation given and procedure performed within the inpatient admission.

Coders **must**:
- **verify** clinical concepts on the discharge summary (or equivalent) by reviewing documentation in the current episode of care before assigning codes for those clinical concepts.

- access other systems (such as electronic laboratory, medical imaging or theatre systems) to specify clinical concepts on the discharge summary (or equivalent); and documented in the current episode of care, prior to code assignment.

- **justify** code assignment with documentation in the current episode of care.

Abstract from outside current episode of care

Coders may use sources of documentation prior to the current episode of care, such as:
- past episodes of care (at current or other health facility)
- referral letters and other correspondence
- emergency notes
- outpatient notes

to:
- **clarify** documentation of clinical concepts in the current episode of care;
- **specify** documentation of clinical concepts in the current episode of care; or to
- **determine** the reason for admission.

Documentation specifically pertaining to an episode may be generated/dated after the patient is discharged. However, documentation generated from patient/clinician contact in a subsequent episode or occasion of service is not to be used for abstraction for the current episode of care.

Abstract from shorthand test result documentation

- Shorthand may be used by clinicians as a shortcut for documenting test results.

- Coders **must** not use test result: values, descriptions, symbols and abbreviations in isolation to inform code assignment.

- For shorthand documentation that does not sufficiently describe a condition, coders should clarify the significance of the shorthand with the clinician to inform accurate code assignment. Where this is not possible, assign a code for the condition represented in shorthand 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.*

Example 2
Discharge summary
Principal diagnosis: PUJ calculi

Current episode of care: Patient admitted with colicky abdominal pain. Ureteric calculi and hydronephrosis noted on ultrasound report. Only PUJ calculi documented in notes and discharge summary. Treated with laser lithotripsy and discharged.

10th Edition	11th Edition
N20.1 Calculus of ureter	N13.2 Hydronephrosis with renal and ureteral calculus obstruction
N20.1 assigned as per Coding Rule TN1028 (effective 01 Jan 2016) *Coding from findings on medical imaging (radiological) reports,* "although the classification links ureteric calculus and hydronephrosis, both conditions must be documented or confirmed by the clinician to inform code assignment".	The coder can use the radiology report finding of "hydronephrosis" to add specificity to the documented condition "ureteric calculi".

Coding Rule TN1028 *Coding from findings on medical imaging (radiological) reports* (effective 01 Jan 2016) was retired 30th June 2019. |

Example 3
Discharge summary
Principal diagnosis: Appendicitis

Current episode of care: Patient has appendicectomy for appendicitis. Histology report shows microperforation, but perforation it is not documented in the notes or discharge summary.

Appendicitis with perforation is coded, as the histology finding "microperforation" adds specificity to documented condition "appendicitis".

Example 4
Discharge summary
Principal diagnosis: Cholelithiasis

Current episode of care: Patient has cholecystectomy for gallstones. Histology report shows chronic cholecystitis but is not mentioned in the notes or discharge summary.

Cholelithiasis with cholecystitis can be coded as the histology finding "chronic cholecystitis" adds specificity to documented condition "cholelithiasis".

Documentation of mandatory conditions

During the ICD-10-AM/ACHI/ACS Eleventh Edition public consultation process the ACCD advised that conditions listed as mandatory for coding (such as those listed in ACS 0002 *Additional diagnoses, Additional diagnosis reporting referred to in other standards*; and ACS 0003 *Supplementary codes for chronic conditions)* can be documented by any clinician (i.e. medical officer, nurse, allied health).

Example 5

Patient admitted with exacerbation of bronchiectasis. Patient is seen by physiotherapist to improve drainage. Physiotherapist documents that patient has a current history of depression.

The documentation of current history of depression by a non-medical officer can be used to assign the mandatory supplementary code U79.3 *Depression.*

Abstraction examples

Example 6
Discharge summary
Principal diagnosis: Follow up cystoscopy for previous TCC of bladder.

Current episode of care: TCC of bladder wall found. No documentation of previously eradicated site.

The coder can abstract from documentation prior to the current episode of care to assign a code for the original primary site as per ACS 0237 *Recurrence of malignancy.*

Example 7
Discharge summary
Principal diagnosis: Fracture distal radius/ulna following fall

Current episode of care: fall from height.

The coder can abstract from documentation prior to the current episode of care (emergency and ambulance documentation) to specify the mechanism of the fall (from tree), place of occurrence (park) and the activity at the time of the fall (playing).

Example 8
Discharge summary
Principal diagnosis: Cerebral palsy

Current episode of care: no documentation of the type of cerebral palsy.

The coder can abstract from documentation prior to the current episode of care (outpatient documentation, referral letters) to specify the type of cerebral palsy (diplegic, hemiplegic).

Example 9
Discharge summary
Principal diagnosis: For MRI under GA.

Current episode of care: no documentation of the reason (indication) for the MRI.

The listing of clinical concepts (e.g. diseases and interventions) on the front sheet and/or discharge summary (or equivalent) is the responsibility of the clinician.

In some circumstances an intervention may be reason for the health service encounter for reasons other than a current illness or injury (for example, change of ureteric stent or removal of metalwork).

In Example 10, it is inappropriate for the intervention (MRI) to be the principal diagnosis as there are no lead terms to classify the intervention in ICD-10-AM Alphabetic Index. Attempts should be made to have the clinician identify the principal diagnosis or condition necessitating the procedure.

As per the Introduction to the *Australian Coding Standards*, sometimes reference to the appropriate section of ICD-10-AM and ACHI will be enough to explain to a clinician what is required for both diagnosis and procedure descriptions. If this action is unsuccessful, the hospital management should be informed of the inadequacy of clinical record documentation and the resultant effect on the hospital's inpatient data.

In the absence of further clarification, the coder can abstract from documentation prior to the current episode of care (outpatient documentation, referral letters) to determine the reason for the MRI, i.e. the principal diagnosis.

Example 10
Episode of care: 1 July – 10 July
Discharge summary written 10 July
Principal diagnosis: LRTI

Letter written 14 July by treating Consultant: Patient presented with a LRTI on 1 July. Treated with IV antibiotics for pneumonia. Discharged 10 July.

The coder may abstract from the Consultant letter as it specifically pertains to the current episode of care and was not generated from patient/clinician contact in a subsequent episode or occasion of service. Documentation should be assessed on a case by case basis, taking into consideration that merit should be given to senior clinician documentation over that of junior clinicians.

Example 11
Discharge summary: Hospital B, 1 May – 14 May
Principal diagnosis: Pneumonia exacerbating COPD.
History: Hypertension, current smoker.

Hospital B (current episode of care), progress notes on 4 May: sepsis with positive blood culture

Discharge summary: Hospital A, 29 Apr - 1 May
Principal diagnosis: Pneumonia for transfer to Hospital B
Investigations: blood collection with positive culture
History: Smoking related COPD.

Hospital B coder can abstract from documentation prior to the current episode of care (Hospital A discharge summary) to determine the condition onset flag for sepsis. Documentation of 'Smoking related COPD' was found incidentally whilst abstracting specificity for sepsis, but cannot be used to inform code assignment as per the ACCD 11th Edition FAQs - amended 28 Jun 2019 'Documentation'.

Example 12
Discharge summary
Principal diagnosis: URTI
History: Diabetes, hypertension

Current episode: Diabetes is documented on the discharge summary and in the progress notes. No complications are documented. The type of diabetes is not documented.

The coder can abstract from documentation prior to the current episode to further specify the type of diabetes.

However, as per the ACCD 11th Edition FAQs - amended 28 Jun 2019, because there is no documentation of diabetes complications/manifestations in the current episode, it is not acceptable to use documentation prior to the current episode to assign codes for complications/manifestations of diabetes.
There remains uncertainty in regards to this Eleventh Edition FAQ advice as it is inconsistent with classification instruction in ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* that severity of diabetes should always be coded. This will be queried with IHPA.

Note: diabetes must be documented in the current episode of care in order for it to be coded.

Example 13
Patient admitted for strabismus surgery on left eye.

The coder can look outside the current episode of care to ascertain if the patient has had previous strabismus surgery on the left eye as there is an *Excludes note* for reoperation procedures for strabismus at Block 216 *Procedures for strabismus*. The 11th Edition FAQs state that the conventions and instructional notes of the classification need to be clearly understood by clinical coders and applied mandatorily.

Example 14
Patient admitted for palliative chemotherapy for prostate adenocarcinoma.

Documentation such as "palliative", "advanced" or "terminal" may be suggestive of metastatic cancer and requires the coder to abstract and assign codes for any metastatic sites to add specificity to the documented condition, as per ACS 0010 *Clinical documentation and general abstraction guidelines* and ACS 0236 *Neoplasm coding and sequencing*. Abstraction from documentation prior to the current episode may be required.

Example 15
Patient admitted for chemotherapy for breast cancer.

Following publication of the ACCD 11th Edition FAQs - amended 28 Jun 2019 there remains uncertainty in regards to abstracting from documentation prior to the current episode of care for coding metastases from a primary neoplasm documented within the current episode of care, without documentation of metastases in the current episode. This will be queried with IHPA.

In the meantime, each episode should be assessed on a case by case basis and it may be appropriate to abstract from documentation prior to the current episode of care to add specificity (primary site, morphology, and metastases) to the documented condition "breast cancer", in accordance with ACS 0010 *Clinical documentation and general abstraction guidelines* and ACS 0236 *Neoplasm coding and sequencing*.

Guidelines for generating appropriate queries to clinicians

- The need to generate a query **must**:
  - be decided upon after completion of abstraction; and
  - be guided by ICD-10-AM/ACHI conventions, ACS and National and State Coding Rules.

- Guidelines and example query formats in ACS 0010 should be used in conjunction with the Clinical Coding Practice Framework to assist with generation of appropriate queries to clinicians.

- All queries, regardless of mode undertaken, **should be written** so that they:
  - include information about the patient, with direct reference to the documentation that has prompted the query. When submitting written clinician queries, it is considered best practice for the medical record to accompany the query as part of the query process.
  - enhance the clinical truth of the documentation, to complete the clinical picture of the current admitted episode of care and support continuity and quality of patient care.
  - allow clinicians to elaborate on (add context to) their response, regarding the significance and cause of the diagnosis/condition/event or intervention.

- Queries **should not**:
  - include prompting or leading questions that instruct or indicate a desired response from a clinician.
  - indicate details for potential financial gain or avoidance of financial loss.

- Queries are considered **appropriate** when the documentation in the current episode of care:
  - is ambiguous, conflicting, illegible or incomplete.
  - describes or is associated with clinical findings (e.g. *Escherichia coli* blood culture) without a definitive relationship to an underlying diagnosis (e.g. sepsis).
  - includes clinical findings, diagnostic evaluation and/or treatment not related to a specific documented condition or intervention.
  - provides a diagnosis without underlying clinical validation.
  - is unclear for condition onset flag (COF) assignment.
  - has discrepancies between investigation results and clinical documentation.
  - includes diagnoses recorded on the discharge summary which are not supported in the health care record.
  - shows commencement of a new medication for which no indication was documented.

Recording queries

- The outcome of concurrent queries (generated prior to patient discharge) performed by CDIS's form part of the documentation in the current episode of care.

- However, queries generated retrospectively **should** have the outcome documented on a query form and be filed as part of the documentation for the episode of care being classified. As per the ACCD 11th Edition FAQs - amended 28 Jun 2019, the query response is acceptable as an update to the episode of care and to inform accurate clinical coding. There is no need for the clinical documentation to be updated.

- The preferred method for queries is written, however, on the occasions where a verbal query is required it should still be transcribed into writing and include the points below.

- Query forms **should** include:
  - An appropriately worded query.
  - An indication of the process undertaken to obtain the answer (e.g. e-mail, verbal and telephone).
  - The date the answer was obtained.
  - The name, designation and signature of the clinician consulted.
  - The name, designation and signature of the personnel who consulted with the clinician.

Query examples

Example 16
Current episode of care: Smokes 15 cigarettes/day.
Previous episode of care: COPD due to smoking

ACS 0503 *Drug, alcohol and tobacco use disorders* instructs: Z72.0 *Tobacco use, current* is assigned when there is insufficient documentation available to assign F17.2 *Tobacco dependence syndrome* or F17.1 *Harmful use of tobacco*.

The coder should assign Z72.0 as the ACCD 11th Edition FAQs - amended 28 Jun 2019 state that the code for harmful use cannot be assigned where there is documentation of only 'smoker' or 'ex-smoker' in the current episode of care (with no further detail), with documentation of harmful use in a previous episode of care.

Example 17
Discharge summary: Emphysema
History: Hepatitis B

Current episode of care, integrated progress notes: Hepatitis B. No documentation of hepatitis stage.

Electronic laboratory system: No hepatitis results.

Outside current episode of care: no documentation of hepatitis stage.

ACS 0104 *Viral hepatitis* instructs that the coder should query the clinician on whether the hepatitis is at the acute or chronic stage, therefore it is **appropriate** to generate a query to the clinician.

Acknowledgement

Supporting information

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