Government of Western Australia
Department of Health

Preview of Twelfth Edition Changes

ACS 0002 Additional diagnoses

WA Clinical Coding Authority

Purchasing and System Performance Division

May 2022

Produced with resources available prior to release of IHPA Education

The **intent** of ACS 0002 *Additional diagnoses* **has not changed for 12th Edition** but it's undergone a wording and formatting refinement. A summarised refresher of the three ACS 0002 criteria and the instructions for assigning family and personal history codes, with reference to the standard's refined wording, follows.

To apply the instructions in ACS 0002 *Additional diagnoses*, coders must have access to all required documentation for classification.

See also *Preview of 12th Edition Changes: ACS 0010 Clinical documentation and general abstraction guidelines*.

Criterion 1
Commencement, alteration and adjustment of therapeutic treatment

12th Edition changes to 'therapeutic treatment'

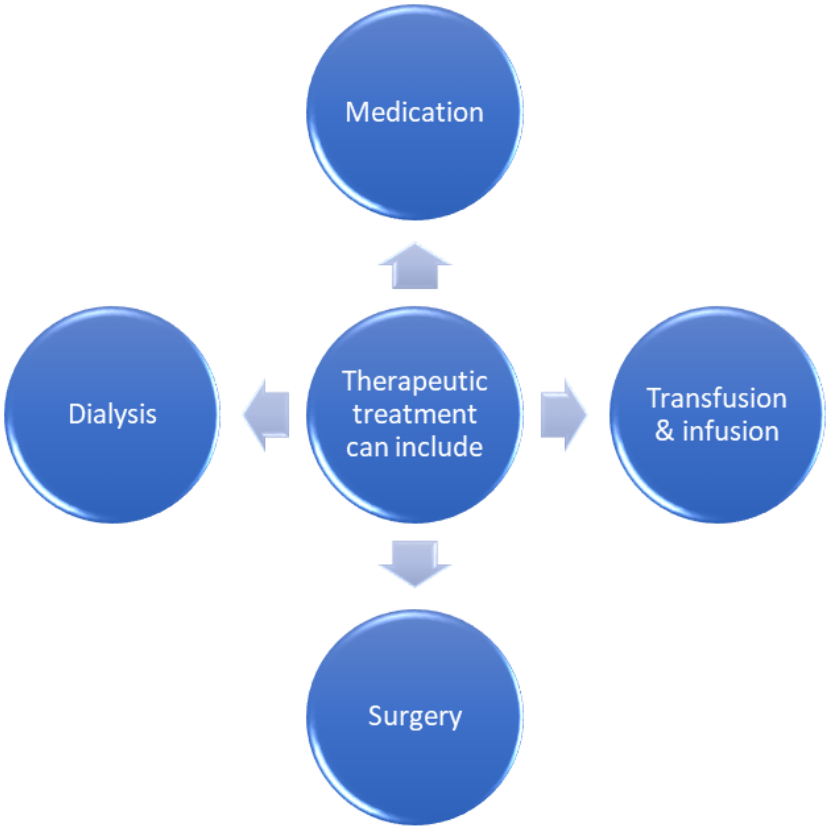
- The terms "significant", "major" and "minor" have been removed from this criterion due to subjectivity in their meaning.

- Clarification that **nurse-initiated medication**, without the need for clinician consultation, does not meet the 'therapeutic treatment' criteria for coding.

- Relocation of instruction "Do not assign an additional diagnosis code for a condition that is referred for follow-up care after discharge only" from the *Incidental Findings* section of ACS 0002 to the 'therapeutic treatment' criterion.

- Retirement of National Coding Advice/IHPA Coding Rule TN1505 *Eleventh Edition FAQs Part 1: Ongoing anticoagulation therapy* (Effective 1 Jul 2019 to 30 Jun 2022). The logic regarding ongoing medication for a pre-existing condition, including when medication is adjusted for management of another condition, has been clarified in the 12th Edition "therapeutic treatment" criterion.

Examples of 'therapeutic treatment'



12th Edition 'therapeutic treatment'

Excerpts from 12th Edition ACS 0002 *Additional diagnoses - Commencement, alteration or adjustment of therapeutic treatment* criterion are reproduced below:

Commencement, alteration or adjustment of therapeutic treatment

Assign an additional diagnosis code for a condition that requires commencement, alteration or adjustment of therapeutic treatment (see Examples 1, 2, 4, 5 & 16).

- **Do not assign** an additional diagnosis code for a condition that is referred for follow-up care after discharge **only** (see Example 17).

- **Do not assign** an additional diagnosis code for a condition that is managed by administration of medication that is initiated as part of general nursing care without the need for clinician consultation (review) or follow-up (eg Mylanta for heartburn; paracetamol for headache; Sominex for insomnia; zinc oxide cream for nappy rash) (see Examples 6 & 7).

- **Do not assign** an additional diagnosis code for a condition that is referred for follow-up care after discharge **only** (see Example 17).

- **Do not assign** an additional diagnosis code for a pre-existing condition where existing treatment is not altered or adjusted; this includes where:
  - ongoing medication is continued
  - ongoing medication for a condition is only adjusted or altered to manage another condition (see also ACS 0303 *Anticoagulant use and abnormal coagulation profile*), such as:
    - reducing a diuretic (prescribed for pre-existing congestive cardiac failure) due to acute kidney injury
    - reducing an antihypertensive (prescribed for pre-existing hypertension) due to onset of hypotension.

IHPA stated: Coders should be familiar and competent with their organisation's admission routines as these vary widely between facilities.

Assign an additional diagnosis code for a condition that results in an alteration to the patient's existing care plan, ie where the condition requires additional care from the treating team, such as:

- an intervention being delayed/changed/cancelled due to a pre-existing condition
- patient requiring admission to the intensive care unit following surgery for a condition that would normally be managed in the surgical ward postoperatively (see Example 3).

- **Do not assign** an additional diagnosis code for a condition that results in an alteration to the patient's existing care plan or diagnostic work-up, but the condition itself does not require additional care from the treating team, such as:
  - ordering a non-contrast CT scan instead of a contrast CT scan in patients with chronic kidney disease
  - selection of non-hepatotoxic agents in patients with chronic liver disease.

See also ACS 0011 *Intervention cancelled or not performed.*

12th Edition 'therapeutic treatment' examples

Example 1.1 – Medication administration: nurse-initiated vs clinician consultation

During admission, patient complains of headache.

Scenario 1 - Paracetamol administered by nurse with no clinician involvement. Headache is **not coded** as an additional diagnosis because paracetamol is initiated by nurse alone.

Scenario 2 - Clinician asked to review patient and prescribes paracetamol for headache which is documented in the progress notes. Nurse administers the paracetamol. Headache is **coded** as an additional diagnosis because therapeutic treatment is commenced by a clinician.

EXAMPLE 1.2 - Nursing care: routine vs non-routine

Scenario 1 - Frequent turning in bed and foam pillows implemented by nursing staff as prophylaxis for pressure injuries. Prophylactic actions to prevent pressure injuries are routine nursing care, so an additional diagnosis is **not coded** for this scenario.

Scenario 2 – On admission, a grade 1 pressure injury is documented in the progress notes by the nurse. A plan for daily dressings is commenced. Pressure injury is **coded** as an additional diagnosis because pressure injury treatment, including dressings, is separate to routine general nursing care which aims to prevent pressure injuries.

During the ITG process IHPA clarified:

- Prophylactic actions for pressure injuries are routine nursing care.
- Treatment of pressure injuries, including dressings, is separate to routine nursing care.

EXAMPLE 1.3 – Coding pre-existing conditions with continuation of pre-existing treatment

Patient admitted for treatment of pneumonia. Patient also undergoes routine dialysis for stage 5 chronic kidney disease.

Assign
Principal diagnosis: J18.9 *Pneumonia, unspecified*

Additional diagnosis: N18.5 *Chronic kidney disease, stage 5*

Rationale
Chronic kidney disease (N18.5) **meets the ACS 0002** 'therapeutic treatment' criterion for code assignment. Despite kidney disease being pre-existing and dialysis being part of existing treatment, IHPA confirmed (during the ITG process) that dialysis is a therapeutic treatment not excluded by the ACS 0002 'Do not assign' instructions under the 'therapeutic treatment' criterion (continuation of ongoing medication is the only exclusion).

EXAMPLE 1.4 - Coding pre-existing conditions with continuation of pre-existing treatment

Patient presents to Emergency Department following large PR bleed. Bloods taken in ED indicate anaemia so packed cells are started. Transfusion continues on the ward after patient admitted.

Anaemia is **coded** as an additional diagnosis for the admitted episode because continuation of a therapeutic treatment such as blood transfusion meets the *Commencement, alteration and adjustment of therapeutic treatment* criterion for code assignment. In line with IHPA's comment described in EXAMPLE 1.3, blood transfusion is a therapeutic treatment not excluded by the ACS 0002 'Do not assign' instructions under the 'therapeutic treatment' criterion (continuation of ongoing medication is the only exclusion).

EXAMPLE 1.5 – Multiple episodes in an admitted patient stay

Patient admitted for treatment of fractured neck of femur under Acute Care Type. Following clinician review, patient commenced oral antibiotics for UTI. Patient is statistically discharged to Rehabilitation Care Type while completing their course of antibiotics. There is no alteration or adjustment of the antibiotics, and no further management of the UTI during the rehabilitation episode.

Acute episode - UTI is **coded** as an additional diagnosis because therapeutic treatment (antibiotics) was commenced by a clinician.

Rehabilitation episode - UTI is **not coded** as an additional diagnosis because the antibiotics were administered for a pre-existing condition and there was no alteration or adjustment to the existing therapeutic treatment for the UTI. ACS 0002 instructs: continuation of ongoing medication does not meet the *Commencement, alteration and adjustment of therapeutic treatment* criterion for code assignment.

Criterion 2
Diagnostic interventions

12th Edition changes to Diagnostic interventions

- The terminology “diagnostic tests” has been replaced with “diagnostic interventions.”

12th Edition Diagnostic interventions instructions

Diagnostic interventions

Assign an additional diagnosis code for a condition if a diagnostic intervention is performed for the purpose of investigating a symptom to determine a diagnosis (see Examples 8, 9 & 10), or to provide specificity to an established diagnosis, such as:

- CT scan to determine extent of ankle fractures
- GFR test to determine stage of chronic kidney disease
- ECG to determine type of myocardial infarction

During the ITG process IHPA clarified that documentation of treatments/ interventions/care by any clinician may be considered in the abstraction and coding process (including for additional diagnosis code assignment relating to the *Diagnostic interventions* criterion).

During the ITG process it was agreed that diagnostic interventions include non-invasive investigations and assessments.

12th Edition Diagnostic interventions examples

EXAMPLE 2.1 - Diagnostic intervention: criterion met
Following surgery, a patient is confused and disorientated. CT brain is performed to rule out sinister causes - none found.

☑

R41.0 *Disorientation, unspecified* is **assigned** as an additional diagnosis because a diagnostic intervention (CT brain) is performed to investigate symptoms (confusion, disorientation) for the purposes of determining a diagnosis. No diagnosis is identified, so the symptoms are coded.

EXAMPLE 2.2 - Diagnostic intervention: criterion not met
Patient admitted for inguinal hernia repair. Postoperative bloods ordered, with result showing low iron. No other documentation about ‘low iron’ in the body of the current episode.

☒

Do not assign a code for ‘low iron’ as an additional diagnosis because the bloods were not performed specifically to investigate iron levels or a symptom indicating low iron.

Criterion 3
Increased clinical care

12th Edition changes to Increased clinical care

- 'Performance of a therapeutic treatment/intervention for a condition' has been removed as an example of increased clinical care.

- Relationship between *Increased clinical care* and *Commencement, alteration or adjustment of therapeutic treatment* criterion clarified.

- The following definitions have been refined and relocated to the new ACS *Glossary of terms*:
  - Care plan
  - Clinical consultation
  - Routine care

- It's been clarified that a 'care plan' includes:
  - a plan to monitor/observe.
  - a plan that is not able to be commenced.
  - transfer to another facility with documentation of the reason for transfer.

12th Edition Increased clinical care instructions

Application of the *Increased clinical care* criterion requires understanding of:

- routine care
- routine postoperative care (go to ACS 1904 *Procedural complications*)
- increased clinical care
- clinical consultation
- care plan

📖 *IHPA education should focus on 'routine care,' 'routine postoperative care,' 'increased clinical care' and 'care plans.'*

Summarised excerpt from the new ACS *Glossary of terms*

Term	Description
Care plan	**Intended health care activities (eg tests, treatments) for patient care, planned to be carried out in the episode.** Evidenced by documentation: • by clinicians responsible for providing care to the patient. • identifying a condition and the planned actions of medical/nursing/allied health clinicians for a patient in the episode. • in many parts of the health care record but typically in the progress notes or on a clinical pathway.
Clinical consultation	**A clinician's review in relation to care of a patient that may involve interactions with the patient, other clinicians or review of the patient's health care record.** Synonyms: • Clinical review • Clinical assessment Evidenced by documentation: • in the patient's health care record. Clinicians include: • the treating medical or surgical clinician • anaesthetists • other consulting health professionals who • document in the health care record. • allied health professionals • midwives • nurses

Routine care	**Services provided to a patient to support logistical, welfare, personal, health care requirements that do not require a care plan.**
	
	May:
	• vary according to the services provided by the health facility and should be considered in the context of the health service providing care.
	• include:
	  ○ administering ordered medication
	  ○ meal services
	  ○ personal hygiene
	  ○ assisting patients to complete other self-care activities
	  ○ preventative health care, eg turning patients in bed
	  ○ taking vital signs, observations
	  ○ provision of equipment to enable the above care
	  ○ recording of pre-existing conditions, statuses

Increased clinical care instructions

Assign an additional diagnosis code for a condition, where:

- It is not precluded by the 'do not assign' instructions under the *Commencement, alteration or adjustment of therapeutic treatment* criterion.

and

- it requires increased clinical care:

<table>
<tr><td rowspan="8">Increased clinical care is evidenced by documentation of →</td><td colspan="2">Clinical consultation</td></tr>
<tr><td colspan="2">AND</td></tr>
<tr><td rowspan="6">Care plan to manage condition in the episode.

Care plans include →</td><td>1.
Increased monitoring/observation.</td></tr>
<tr><td>2.
Confirmation to continue with existing plan.</td></tr>
<tr><td>3.
Transfer to another facility with documentation of reason(s) for transfer.</td></tr>
<tr><td>4.
Education/training to manage a condition.</td></tr>
<tr><td>5.
Exercise/rehabilitation program to manage a condition.</td></tr>
<tr><td>6.
A plan, not able to be commenced. See ACS 0011 Intervention cancelled or not performed.</td></tr>
</table>

12th Edition Increased clinical care examples

EXAMPLE 3.1 – Midwife consultation, observation and education

In a delivery episode, patient is reviewed by the midwife who documents:

Progress notes
Nipple graze: For attachment checks/education.

Code assignment
Assign Principal diagnosis O80-O84 *Delivery* Additional diagnoses Z37 *Outcome of delivery* O92.20 *Other and unspecified disorders of breast associated with childbirth, without mention of attachment difficulty* **Rationale** 'Nipple graze' (O92.20) meets ACS 0002 criteria for code assignment because it required increased clinical care as evidenced by documentation of: ▪ a review by the midwife (clinical consultation) and ▪ a plan for breast feeding attachment checks and education (care plan for increased observation and education).

EXAMPLE 3.2 – Medical officer consultation and observation

Patient admitted for treatment of depression. On admission, medical officer assesses the patient and documents:

Progress notes
Suicidal ideation. Plan: 15 min nursing checks.

Code assignment
Assign Principal diagnosis F32.90 *Depressive episode, unspecified, not specified as arising in the postnatal period* Additional diagnosis R45.81 *Suicidal ideation* **Rationale** 'Suicidal ideation' (R45.8) meets ACS 0002 criteria for code assignment because it required increased clinical care as evidenced by documentation of: ▪ an assessment by the medical officer (clinical consultation) and ▪ a plan for 15 minute nursing checks (care plan for increased observation).

EXAMPLE 3.3 – Care plan not commenced and transfer to another facility

On admission, medical officer assesses the patient and documents:

Progress notes 1.7 1400
Impression
- *Pneumonia – Kleb. Pneumoniae. For IV Ceftriaxone.*
- *Alcohol abuse. For Alcohol Withdrawal Scale.*

Later medical officer documents:

Progress notes 1.7 1600
In retrospect, ATSP at 1430 with 9/10 chest pain, diaphoresis, shortness of breath. ECG ST elevation. Elevated troponins.
Impression: acute myocardial infarction.
Given GTN, Aspirin and transferred to another health facility for coronary angiography + percutaneous coronary intervention.

Code assignment

Assign
Principal diagnosis
J15.0 *Pneumonia due to klebsiella pneumoniae*

Additional diagnosis
Z15.9 *Resistance to antibiotic, unspecified*
U93 *Extended spectrum beta-lactamase [ESBL] producing organism*
F10.1 *Mental and behavioural disorders due to use of alcohol, harmful use*
I21.3 *Acute transmural infarction of unspecified site*

Rationale
'Alcohol abuse' (F10.1) meets ACS 0002 criteria for code assignment because it required increased clinical care as evidenced by documentation of:
- an assessment by the medical officer (clinical consultation) and
- a plan for monitoring for symptoms of alcohol withdrawal using the Alcohol Withdrawal Scale (care plan for increased monitoring). This plan however, was unable to be commenced due to an unexpected transfer to another facility.

'Acute myocardial infarction (I21.3) meets ACS 0002 criteria for code assignment because it required increased clinical care as evidenced by documentation of:
- an assessment by the medical officer (clinical consultation) and
- a plan to transfer the patient to another facility, including the reason(s) for transfer.
- Note: I21.3 also meets the ACS 0002 'therapeutic treatment' criterion for code assignment because it required commencement of GTN and Aspirin (commencement of therapeutic treatment).

EXAMPLE 3.4 – Medical officer consultation and care plan not commenced

Patient admitted for ablation of endometriosis. Following surgery, medical officer visits the patient and documents:

> Progress notes
> *Bloods show iron deficiency anaemia. Plan: iron infusion then discharge.*
> *Note, patient declining infusion → discharge.*

Code assignment
Assign Principal diagnosis N80.9 *Endometriosis, unspecified* Additional diagnosis D50.9 *Iron deficiency anaemia, unspecified* **Rationale** 'Iron deficiency anaemia' (D50.9) meets ACS 0002 criteria for code assignment because it required increased clinical care as evidenced by documentation of: ▪ a visit by the medical officer (clinical consultation) and ▪ a planned iron infusion that was unable to be commenced.

EXAMPLE 3.5 – Medical officer consultation and monitoring: neonatal

On initial assessment of singleton, medical officer documents:

> Progress notes
> *TTN and bradycardia for monitoring in SCU.*

Code assignment
Assign Principal diagnosis P22.1 *Transient tachypnoea of newborn* Additional diagnosis P29.1 *Neonatal cardiac dysrhythmia* Z38.0 *Singleton, born in hospital* **Rationale** 'Bradycardia' (P29.1) meets ACS 0002 criteria for code assignment because it required increased clinical care as evidenced by documentation of: ▪ an assessment by the medical officer (clinical consultation) and ▪ a plan to monitor the bradycardia in the special care unit (care plan for increased monitoring).

EXAMPLE 3.6 – Specialist team consultation and no intervention required: neonatal

On initial assessment of singleton, medical officer documents:

> Progress notes
> *Respiratory distress → transfer to special care nursery.*
> *Also 2x neonatal teeth. Discussed with dental team at Children's Hospital who advised no intervention required.*

Code assignment
Assign Principal diagnosis P22.9 *Respiratory distress of newborn, unspecified* Additional diagnosis K00.6 *Disturbances in tooth eruption* Z38.0 *Singleton, born in hospital* **Rationale** 'Neonatal teeth' (K00.6) meet ACS 0002 criteria for code assignment because they required increased clinical care as evidenced by documentation of: ▪ a medical officer's consultation with a specialist team and ▪ a decision to continue with existing care, ie no intervention required (care plan to continue with existing care).

EXAMPLE 3.7 – Routine care

Patient admitted via the Emergency Department for surgical treatment of acute appendicitis. On the pre-anaesthetic form, the anaesthetist documents:

> *Morbid obesity, BMI 36 for bariatric bed/wheelchair.*

Code assignment
Assign Principal diagnosis K35.8 *Acute appendicitis, other and unspecified* Additional diagnosis U78.1 *Obesity* **Rationale** 'Morbid obesity' does not meet ACS 0002 criteria for code assignment because it didn't require increased clinical care. No care plan to manage the obesity has been documented in the episode. Provision of -equipment to support logistical, welfare, personal and health care requirements that does not require a care plan, is considered 'routine care.' U78.1 is assigned as per ACS 0003.

Family and personal history

12th Edition changes to Family and personal history

- The terminology “relevant” has been replaced with “related.”

- Clarification of code ranges applicable to this section of ACS 0002:
  - Family history of diseases and disorders: Z80, Z82–Z84
  - Personal history of diseases and disorders: Z85–Z88, Z91–Z92
  - Certain conditions influencing health status (eg acquired absence, presence of, dependence on): Z89, Z90, Z93–Z99.

- Changes to National Coding Advice/IHPA Coding Rules with “history” content:
  - Update to Q2640 *Cause of death and ACS 0002 Additional diagnoses* (Effective 1 Jul 2011 to current).
  - Update to Q3612 *Medicinal cannabis* (Effective 1 Jul 2011 to current)
  - Retirement of TN1505 *Eleventh Edition FAQs Part 1: Ongoing anticoagulation therapy* (Effective 1 Jul 2019 to 30 Jun 2022).

12th Edition Family and personal history instructions

Family and personal history, and certain conditions influencing health status

Assign additional diagnosis codes for a personal or family history of diseases and disorders, or statuses (eg artificial opening, organ transplantation, presence of functional implants, graft or other device, dependence on enabling machines or devices) classified to the following blocks and categories when they are documented as being related to a condition being managed or an intervention being performed in the current episode of care:

- Family history of diseases and disorders: Z80, Z82–Z84
- Personal history of diseases and disorders: Z85–Z88, Z91–Z92
- Certain conditions influencing health status (eg acquired absence, presence of, dependence on): Z89, Z90, Z93–Z99.

12th Edition Family and personal history examples

EXAMPLE 4.1 - Personal history with relationship to intervention performed: 'related'

Patient admitted for treatment of infected open wound. Patient history of allergic reaction to penicillin. Infectious diseases team consulted, who advised the previous reaction was minor, to commence the patient on Amoxicillin and monitor for any reaction. Patient discharged without incident.

Z88.0 *Personal history of allergy to penicillin* is **assigned** as an additional diagnosis because the history (previous reaction to penicillin) was related to the decision making for an intervention (selection of antibiotic).

EXAMPLE 4.2 – Family history without relationship to intervention performed: 'not related'

Patient admitted for investigation of haematuria, difficulty urinating and loss of appetite. Patient reports family history of bladder and breast cancer. Given family history of bladder cancer, cystoscopy ordered.

Z80.5 *Family history of malignant neoplasm of urinary tract* is **assigned** as an additional diagnosis because family history of bladder cancer is documented as being related to an intervention (cystoscopy) being performed.

A code for history of breast cancer is **not assigned** as an additional diagnosis because there is no documented relationship to any condition being managed or intervention performed.

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