



IHPA

## ICD-10-AM/ACHI/ACS Eleventh Edition

Errata 3, December 2019

For implementation 1 January 2020

### ICD-10-AM Alphabetic Index

#### Page 16

##### Amend term

**Adhesions, adhesive** (postinfective) K66.0  
 ...  
 - peritoneum, peritoneal (male) K66.0  
 - - with intestinal obstruction K56.5  
 - - congenital Q43.32  
 - - female pelvic (postpartal) (to uterus) N73.6  
 - - - affecting  
 - - - - labour **and-or** delivery O65.5  
 - - - - pregnancy O34.8  
 - - - postprocedural N99.4  
 ...

#### Page 258

##### Delete subterms and codes

	Malignant				Uncertain or unknown behaviour
	Primary	Secondary	In situ	Benign	
<b>Neoplasm, neoplastic – continued</b>					
- hemisphere, cerebral.....	C71.0	C79.3	-	D33.0	D43.0
- hepatic.....	C22.9	C78.7	D01.5	D13.4	D37.6
- - duct (bile).....	C24.0	C78.8	D01.5	D13.5	D37.6
- - flexure (colon).....	C18.3	C78.5	D01.0	D12.3	D37.4
<del>- - primary.....</del>	<del>C22.9</del>	<del>-</del>	<del>D01.5</del>	<del>D13.4</del>	<del>D37.6</del>
- hepatobiliary.....	C24.9	C78.8	D01.5	D13.9	D37.6

#### Page 261

##### Delete subterms and codes

	Malignant				Uncertain or unknown behaviour
	Primary	Secondary	In situ	Benign	
<b>Neoplasm, neoplastic – continued</b>					
- liver.....	C22.9	C78.7	D01.5	D13.4	D37.6
<del>- - primary.....</del>	<del>C22.9</del>	<del>-</del>	<del>D01.5</del>	<del>D13.4</del>	<del>D37.6</del>

## ACHI Alphabetic Index

### Page 48

#### Delete subterm and cross reference

**Cystectomy** — *see also Excision/cyst*  
- gallbladder — *see Cholecystectomy*  
- ovary (para-ovarian)  
~~--- with hysterectomy — see Hysterectomy~~  
- - bilateral  
- - - laparoscopic 35638-05 [1244]  
- - - via laparotomy 35717-00 [1244]  
- - unilateral  
- - - laparoscopic 35638-04 [1244]  
- - - via laparotomy 35713-04 [1244]  
- urinary  
- - partial (open) 37000-01 [1102]  
- - - via laparoscopy 37000-00 [1102]  
- - total (radical) 37014-00 [1102]

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#### Delete subterm and cross reference

**Excision** — *see also Removal*  
...  
- osteophyte  
- - ankle  
- - - arthroscopic (closed) 49703-01 [1531]  
- - joint structure NEC 90574-00 [1561]  
- ovary — *see Oophorectomy*  
- - with excision of fallopian tube — *see Salpingo-oophorectomy*  
~~--- and hysterectomy — see Hysterectomy~~  
- palate  
- - bony (hard) (soft) 90141-02 [403]

### Page 149

#### Delete subterms, nonessential modifiers and codes. Add subterms, nonessential modifiers and codes

**Myringotomy** (unilateral) 41626-00 [309]  
~~--- with~~  
~~--- aspiration 41626-00 [309]~~  
~~--- and intubation (grommet) 41632-02 [308]~~  
~~--- drainage of abscess 41626-00 [309]~~  
~~--- and intubation (grommet) 41632-02 [308]~~  
~~--- insertion of tube (grommet) 41632-02 [308]~~  
- bilateral 41626-01 [309]  
- - with  
- - - aspiration 41626-01 [309]  
- - - - and intubation (grommet) 41632-03 [308]  
- - - drainage of abscess 41626-01 [309]  
- - - - and intubation (grommet) 41632-03 [308]  
- - - insertion of tube (grommet) 41632-03 [308]  
~~- unilateral 41626-00 [309]~~  
~~- - with~~  
~~- - - aspiration 41626-00 [309]~~  
~~- - - - and intubation (grommet) 41632-02 [308]~~  
~~- - - drainage of abscess 41626-00 [309]~~  
~~- - - - and intubation (grommet) 41632-02 [308]~~  
~~- - - insertion of tube (grommet) 41632-02 [308]~~

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**Delete subterm and cross reference**

**Oophorectomy**

- with excision of fallopian tube — see *Salpingo-oophorectomy*
- and hysterectomy — see *Hysterectomy*
- bilateral
- - laparoscopic (total) 35638-03 [1243]
- - via laparotomy (total) 35717-01 [1243]
- ...

**Page 233**

**Delete subterm and cross reference**

**Salpingectomy**

- by electrodestruction — see *Electrodestruction/fallopian tube*
- for reversal of sterilisation — see *Anastomosis/fallopian tube*
- with oophorectomy — see *Salpingo-oophorectomy*
- and hysterectomy — see *Hysterectomy*
- bilateral
- - laparoscopic (total) 35638-10 [1251]

**Page 233**

**Delete subterm and cross reference**

**Salpingo-oophorectomy**

- with hysterectomy — see *Hysterectomy*
- bilateral
- - laparoscopic 35638-12 [1252]
- - via laparotomy 35717-04 [1252]

# Australian Coding Standards (ACS)

Page 4

**Update** wording within standard

*See also supplementary document for ACS 0002 Additional Diagnoses remediated version without tracked changes.*

## 0002 ADDITIONAL DIAGNOSES

An additional diagnosis is defined as:

“A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code” (Australian Institute of Health and Welfare, 2018).

Codes assigned for additional diagnoses are a substantial component of the Admitted Patient Care National Minimum Data Set (APC NMDS). “The purpose of the APC NMDS is to collect information about care provided to admitted patients in Australian hospitals” (Australian Institute of Health and Welfare, 2018).

The national morbidity data collection is not intended to describe the current disease status of the inpatient population, but rather the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

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.](#)

Many of the above activities are performed by clinicians in the form of clinical consultation. For the purposes of classification, a clinical consultation refers to documentation provided by the:

- treating clinician/team who is primarily responsible for managing a patient’s condition during the episode of care
- specialist who provides advice/opinion, to the referring clinician/team, regarding a patient’s management
- nurses, midwives and allied health professionals who are engaged in a patient’s management within their scope of practice.

Documentation of a consultation does not have to be a formal consultation report. Documentation of assessment of a condition in the progress notes or elsewhere (eg a care plan) is sufficient. Telephone or electronic consultation with clear documentation of the information exchange is also regarded as a clinical consultation.

~~Note that a condition may be documented by the treating clinician/team due to its ‘clinical significance’, however, for classification purposes some conditions are normally not coded as additional diagnoses in certain circumstances.~~

### COMMENCEMENT, ALTERATION OR ADJUSTMENT OF THERAPEUTIC TREATMENT

- Do not assign an additional diagnosis code for a condition that ~~is transient and~~ can be treated successfully with administration of medication without the need for ~~further clinical~~ consultation, investigation or a plan of care (eg Mylanta for heartburn; paracetamol for headache; Somnex

for insomnia; [zinc oxide cream for nappy rash](#); [Sudocream for groin excoriation](#)) (see Examples 1, 2 & 3, 17 & 19).

~~An additional diagnosis code can be assigned if a condition requires further assessment (ie the condition is no longer considered transient) by a clinician and~~

~~○ a diagnostic or therapeutic intervention is undertaken, or~~

~~○ a care plan is prescribed following clinical consultation~~

~~For example, CT scan of the brain performed to investigate the cause of the headache; altered medication dosage for heartburn; neurological observations ordered following fall; strict fluid balance for fluid overload (see Examples 4 & 15)~~

- Do not assign an additional diagnosis code for a pre-existing condition requiring administration of ongoing medication. This includes where the ongoing medication is adjusted due to the management of another condition (eg reducing dosage of diuretics due to acute kidney injury (AKI) in patients with congestive heart failure (CCF); adjustment of the dose of antihypertensive medication due to hypotension) (see Examples 5 & 6).

An additional diagnosis code can be assigned for a pre-existing condition if a change in the pre-existing condition requires an amendment to its treatment plan (eg increase in diuretics dosage due to exacerbation of congestive heart failure (CCF)) (see Examples 7 & 9)

- 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 (eg 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) (see Example 8).

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 (eg 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* (see Example 10)

- ~~Do not assign an additional diagnosis code for a condition that is treated with nurse initiated medications, or nurse initiated interventions alone (eg applying zinc oxide cream for nappy rash; applying Sudocream for groin excoriation; providing a heat pack for neck pain; giving juice or fruit for hypoglycaemia) (see Examples 11, 17 & 19).~~

~~An additional diagnosis code can be assigned for the above scenario if a condition is subsequently assessed by a clinician/team, and diagnostic or therapeutic intervention(s) performed, or a care plan is commenced for a condition (see Example 12).~~

#### EXAMPLE 1:

Patient was admitted for induction of labour due to reduced fetal movements. In the progress notes, the midwife noted “patient complained of having headaches which resolved with paracetamol. Blood pressure was 135/90 and later 130/80. CTG has been performed awaiting review by clinician. No other concerns voiced”. No investigations were performed for the headache. The patient progressed to delivery later that day.

Principal diagnosis: Delivery

Additional diagnosis: Maternal care for decreased fetal movements

In this example, the headache is not a ~~transient~~ condition that significantly affected patient management in this episode of care, and The headache was treated successfully with administration of medication (paracetamol) without the need for ~~further investigations~~ clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

**EXAMPLE 2:**

Patient was admitted with acute alcohol intoxication. Patient was assessed by a drug and alcohol clinician and alcohol dependence was diagnosed. In the progress notes: “Phenergan 25 mg was given for insomnia”. The medication chart noted ‘Phenergan 25 mg PRN nocte’. No ~~further investigations~~ clinical consultation ~~was~~~~ere~~ undertaken for insomnia during the episode of care.

Principal diagnosis: Acute alcohol intoxication

Additional diagnosis: Alcohol dependence syndrome

In this example, insomnia is not a ~~transient~~ condition that significantly affected patient management in this episode of care, ~~and~~ The insomnia was treated successfully with administration of medication (Phenergan) without the need for ~~further investigations~~ clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

**EXAMPLE 3:**

Patient was admitted for pneumonia. In the progress notes: “patient had PRN gastrogel for reflux with good effect”. No other documentation to indicate that a diagnostic procedure was ordered or a change of treatment was commenced for reflux.

Principal diagnosis: Pneumonia

In this example, the reflux is not a ~~transient~~ condition that significantly affected patient management in this episode of care, ~~and~~ The reflux was treated successfully with administration of medication (Gastrogel) without the need for ~~further investigations~~ clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

...

**EXAMPLE 5:**

Patient with a past history of atrial fibrillation (AF) on aspirin therapy, was admitted with aspirin induced duodenal ulcers. Aspirin was withheld during the episode of care, and the patient was commenced on medication to treat the ulcers.

Principal diagnosis: Duodenal ulcer

Additional diagnosis: Adverse effect from aspirin

In this example, the pre-existing AF does not meet the criteria in ACS 0002 as withholding the aspirin was part of the ~~treatment~~ care plan for the duodenal ulcer, not for management of the AF.

**EXAMPLE 6:**

An elderly patient with hypertension was admitted with postural hypotension, in the context of poor oral intake and dehydration. Patient received rehydration with IV fluids, and his regular antihypertensive medication (perindopril) was withheld due to the postural hypotension.

Principal diagnosis: Postural hypotension

Additional diagnosis: Dehydration

In this example, the pre-existing hypertension does not meet the criteria in ACS 0002, as withholding the perindopril is part of the ~~treatment~~ care plan for postural hypotension; the change is not for management of the hypertension. Assign U82.3 *Hypertension* for the hypertension (see ACS 0003 *Supplementary codes for chronic conditions*).

...

### EXAMPLE 11:

Patient was admitted for febrile neutropenia and reduced oral intake secondary to chemotherapy for left breast cancer. Patient was advised by a nurse to drink more fluids as slightly hypotensive.

Principal diagnosis: Neutropenia  
Additional diagnosis: Drug-induced fever  
Adverse effect from chemotherapy  
Breast cancer  
Morphology code for breast cancer

In this example, the hypotension was not a ~~significant~~ condition that significantly affected patient management in the episode of care, ~~as the~~ patient was only advised to drink more fluids. There was no diagnostic or therapeutic treatment/intervention undertaken, and no care plan was prescribed. ~~;~~ ~~†~~ Therefore, it does not meet the criteria in ACS 0002. Assign codes for the breast cancer as per the guidelines in ACS 0236 *Neoplasm coding and sequencing*.

### EXAMPLE 12:

An 84-year-old female was admitted after a fall. CT scan of head, neck and chest revealed multiple fracture of ribs (4-7) on the left side of chest, which were treated conservatively. Her past medical history included ischaemic heart disease, hypertension, chronic obstructive pulmonary disease (COPD) and falls. On arrival, the patient was examined by the ~~ward~~registered nurse, who diagnosed and documented a stage I pressure injury (PI) on the left heel. A wound care treatment plan was commenced.

Principal diagnosis: Fractures of multiple ribs  
Additional diagnosis: External cause of injury  
Place of occurrence  
Activity  
Pressure injury, stage I, heel

In this example, the pressure injury meets the criteria in ACS 0002 in the episode of care, ~~as the~~ PI was assessed and diagnosed by a registered nurse, and a treatment plan was commenced specifically for the condition. (~~which~~ Assessment and diagnosis of the PI is within the scope of nursing practice).

Assign U82.3 *Hypertension* for the hypertension, U82.1 *Ischaemic heart disease* for the ischaemic heart disease and U83.2 *Chronic obstructive pulmonary disease* for the COPD (see ACS 0003 *Supplementary codes for chronic conditions*).

...

## INCREASED CLINICAL CARE

**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 (eg urinary and bowel), pressure area prevention and skin care, assisting with activities of daily living and mobilisation (see Example 17)
- 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) (see Example 13)

- assessment of pre-existing conditions without a documented care plan specifically for these conditions (eg 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 and management of pain levels and bowel function, deep venous thrombosis and pressure injury prophylaxis (see Example 19)

**Conditions are significant** in an episode of care when clinical care provided for a condition is beyond routine (ie **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 (eg 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 diagnostic statement, ~~or~~ and
  - a care plan for the condition (eg 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 (see Examples 12, 21 & 22)

- performance of a therapeutic treatment/intervention for a condition (see also ACS 0002 Additional diagnoses/Commencement, alteration or adjustment of therapeutic treatment) (~~eg dialysis for end stage renal failure, pharmacotherapy for multiple sclerosis~~) (see Examples 4, 5, 6 & 7)
- pre and postoperative management in excess of routine care (see also ACS 1904 *Procedural complications*) (see Examples 18 & 20)

#### **EXAMPLE 17:**

An 86-year-old man was admitted with community acquired pneumonia. Patient had a long history of urinary incontinence. During the admission, his incontinence pads were changed regularly and zinc oxide cream applied daily to his skin, by the nurse.

Principal diagnosis:                      Pneumonia

In this example, the ~~management of the patient's~~ urinary incontinence is not a condition that significantly affected patient management in this episode of care, and Daily topical application of zinc oxide cream skin is ~~routine~~ general nursing care for this condition; therefore, it does not meet the criteria in ACS 0002.

...

## Add wording

**0534 SPECIFIC INTERVENTIONS RELATED TO MENTAL HEALTH CARE SERVICES**

Specific intervention codes related to mental health care services are included in ACHI Chapter 19 Interventions not elsewhere classified in the following blocks:

...

For admitted episodes of care it is not mandatory to assign code(s) for mental health care interventions with the exception of electroconvulsive therapy [and repetitive transcranial magnetic stimulation](#). However their use is encouraged in specialist mental health care facilities and units to better represent care provided to these patients. It should also be noted that these interventions are not exclusive to mental health and may be assigned outside of this context.

## Amend spelling in example

**0925 HYPERTENSION AND RELATED CONDITIONS****EXAMPLE 4:**

30 year old man presents with headaches, nausea, vomiting and lethargy approximately two weeks after a severe sore throat. He is otherwise healthy with no known previous illness and is taking no medication. Physical examination reveals facial oedema. Blood pressure is 180/110 mmHg. Investigations including kidney biopsy confirmed the diagnosis of postinfectious glomerulonephritis and hypertension secondary to acute kidney disease.

Codes:        N00.9        *Acute nephritic syndrome, unspecified*  
                   I15.1        *Hypertension secondary to other disorders*

...

## Add wording

**1506 FETAL PRESENTATION, DISPROPORTION AND ABNORMALITY OF MATERNAL PELVIC ORGANS****CLASSIFICATION**

...

Where care and/or intervention is required due to malpresentation, disproportion or abnormality of maternal pelvic organs **during** labour [and/or delivery](#), regardless of when the condition is first diagnosed, assign a code from blocks O64–O66 (see exception below regarding uterine scar):

O64    *Labour and delivery affected by malposition and malpresentation of fetus,*  
 O65    *Labour and delivery affected by maternal pelvic abnormality, or*  
 O66    *Other factors affecting labour and delivery.*

Amend code and code title

**1911 BURNS**

...

**EXAMPLE 1:**

Patient admitted with full thickness burns to the inner aspect of the right forearm (2% BSA) and partial thickness of the left hand (6% BSA). Burns were due to boiling water from a coffee plunger, at work.

Codes:	T22.31 <del>2</del>	Full thickness burn of shoulder and upper limb, except wrist and hand, <u>forearm and elbow</u>
	T23.2	Partial thickness [blisters, epidermal loss] burn of wrist and hand
	T31.00	Burns involving less than 10% of body surface, with less than 10 % or unspecified full thickness burns
	X10.0	Contact with hot drink
	Y92.9	Unspecified place of occurrence
	U73.09	While working for income, unspecified

...

Delete index entry

**C**

...

**Chemotherapy-0044, 58**

- for HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) 0102, **65**

Delete index entry and add cross reference

**N**

**Neoplasm(s) 0236, 84**

- chemotherapy-0044, 58 — see [Neoplasm\(s\), pharmacotherapy](#)

- contiguous sites 0234, **83**

...

- pharmacotherapy 0044, **58**



IHPA

## ICD-10-AM/ACHI/ACS Eleventh Edition – Supplementary document

Errata 3, December 2019

For implementation 1 January 2020

### Australian Coding Standards (ACS)

#### 0002 ADDITIONAL DIAGNOSES

An additional diagnosis is defined as:

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Codes assigned for additional diagnoses are a substantial component of the Admitted Patient Care National Minimum Data Set (APC NMDS). “The purpose of the APC NMDS is to collect information about care provided to admitted patients in Australian hospitals” (Australian Institute of Health and Welfare, 2018).

The national morbidity data collection is not intended to describe the current disease status of the inpatient population, but rather the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

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.

Many of the above activities are performed by clinicians in the form of clinical consultation. For the purposes of classification, a clinical consultation refers to documentation provided by the:

- treating clinician/team who is primarily responsible for managing a patient’s condition during the episode of care
- specialist who provides advice/opinion, to the referring clinician/team, regarding a patient’s management
- nurses, midwives and allied health professionals who are engaged in a patient’s management within their scope of practice.

Documentation of a consultation does not have to be a formal consultation report. Documentation of assessment of a condition in the progress notes or elsewhere (eg a care plan) is sufficient. Telephone or electronic consultation with clear documentation of the information exchange is also regarded as a clinical consultation.

## COMMENCEMENT, ALTERATION OR ADJUSTMENT OF THERAPEUTIC TREATMENT

- Do not assign an additional diagnosis code for a condition that can be treated successfully with administration of medication without the need for clinical consultation, investigation or a plan of care (eg Mylanta for heartburn; paracetamol for headache; Somnex for insomnia; zinc oxide cream for nappy rash; Sudocream for groin excoriation) (see Examples 1, 2, 3, 17 & 19).
- Do not assign an additional diagnosis code for a pre-existing condition requiring administration of ongoing medication. This includes where the ongoing medication is adjusted due to the management of another condition (eg reducing dosage of diuretics due to acute kidney injury (AKI) in patients with congestive heart failure (CCF); adjustment of the dose of antihypertensive medication due to hypotension) (see Examples 5 & 6).

An additional diagnosis code can be assigned for a pre-existing condition if a change in the pre-existing condition requires an amendment to its treatment plan (eg increase in diuretics dosage due to exacerbation of congestive heart failure (CCF)) (see Examples 7 & 9)

- 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 (eg 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) (see Example 8).

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 (eg 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* (see Example 10)

### EXAMPLE 1:

Patient was admitted for induction of labour due to reduced fetal movements. In the progress notes, the midwife noted “patient complained of having headaches which resolved with paracetamol. Blood pressure was 135/90 and later 130/80. CTG has been performed awaiting review by clinician. No other concerns voiced”. No investigations were performed for the headache. The patient progressed to delivery later that day.

Principal diagnosis:           Delivery

Additional diagnosis:         Maternal care for decreased fetal movements

In this example, the headache is not a condition that significantly affected patient management in this episode of care. The headache was treated successfully with administration of medication (paracetamol) without the need for clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

### EXAMPLE 2:

Patient was admitted with acute alcohol intoxication. Patient was assessed by a drug and alcohol clinician and alcohol dependence was diagnosed. In the progress notes: “Phenergan 25 mg was given for insomnia”. The medication chart noted ‘Phenergan 25 mg PRN nocte’. No clinical consultation was undertaken for insomnia during the episode of care.

Principal diagnosis:           Acute alcohol intoxication

Additional diagnosis:         Alcohol dependence syndrome

In this example, insomnia is not a condition that significantly affected patient management in this episode of care. The insomnia was treated successfully with administration of medication (Phenergan) without the need for clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

**EXAMPLE 3:**

Patient was admitted for pneumonia. In the progress notes: “patient had PRN gastrogel for reflux with good effect”. No other documentation to indicate that a diagnostic procedure was ordered or a change of treatment was commenced for reflux.

Principal diagnosis:           Pneumonia

In this example, the reflux is not a condition that significantly affected patient management in this episode of care. The reflux was treated successfully with administration of medication (Gastrogel) without the need for clinical consultation, or a care plan; therefore, it does not meet the criteria in ACS 0002.

**EXAMPLE 4:**

Patient was admitted for low back pain. During the hospital stay, patient reported worsening epigastric discomfort and reflux after eating meals. Patient was on regular pantoprazole 20mg prior to admission for ongoing gastro-oesophageal reflux disease (GORD). After clinical review, the dosage of pantoprazole was increased to 40mg daily. Patient’s symptoms had improved by discharge.

Principal diagnosis:           Low back pain

Additional diagnosis:        Gastro-oesophageal reflux disease

In this example, the reflux meets the criteria in ACS 0002 as the dosage of their regular medication (pantoprazole) was increased for the pre-existing GORD after clinical review.

**EXAMPLE 5:**

Patient with a past history of atrial fibrillation (AF) on aspirin therapy, was admitted with aspirin induced duodenal ulcers. Aspirin was withheld during the episode of care, and the patient was commenced on medication to treat the ulcers.

Principal diagnosis:        Duodenal ulcer

Additional diagnosis:        Adverse effect from aspirin

In this example, the pre-existing AF does not meet the criteria in ACS 0002 as withholding the aspirin was part of the care plan for the duodenal ulcer, not for management of the AF.

**EXAMPLE 6:**

An elderly patient with hypertension was admitted with postural hypotension, in the context of poor oral intake and dehydration. Patient received rehydration with IV fluids, and his regular antihypertensive medication (perindopril) was withheld due to the postural hypotension.

Principal diagnosis:        Postural hypotension

Additional diagnosis:        Dehydration

In this example, the pre-existing hypertension does not meet the criteria in ACS 0002, as withholding the perindopril is part of the care plan for postural hypotension; the change is not for management of the hypertension. Assign U82.3 *Hypertension* for the hypertension (see ACS 0003 *Supplementary codes for chronic conditions*).

**EXAMPLE 7:**

A 64-year-old man was admitted with a two day history of central chest pain on a background of advanced pulmonary fibrosis and hypertension. On arrival in the Emergency Department, he had a GCS of 15/15, oxygen saturation of 80% and blood pressure of 185/90. Metoprolol and amlodipine (not his normal medication) were administered for hypertension. He underwent a coronary angiogram and a diagnosis of angina secondary to coronary artery disease was made. During the admission, the patient's low oxygen saturation (documented as due to the pre-existing pulmonary fibrosis) required increased oxygen supplement and Ordine was commenced for shortness of breath. Home oxygen extension was arranged and a Hudson mask was provided on discharge.

Principal diagnosis: Angina pectoris, unspecified

Additional diagnosis: Coronary artery disease

Pulmonary fibrosis

Hypertension

In this example, the pre-existing pulmonary fibrosis and hypertension both meet the criteria in ACS 0002 as therapeutic treatment was given for the hypertension and a care plan (commenced Ordine, home oxygen extension with Hudson mask) commenced for the pulmonary fibrosis.

**EXAMPLE 8:**

Patient with a known chronic kidney disease (CKD) stage 3 was admitted for observation of a head injury after falling down a flight of stairs and suffering a minor laceration to the forehead and a contusion to the abdominal wall. Documentation in the admission notes stated "CKD 10 years, for non-contrast CT scan of head, neck, chest and abdomen to avoid acute kidney injury". Head/neck CT scan showed no fracture of skull, and no swelling or haemorrhage of the brain. Chest/abdominal CT scan was negative for free fluid and organ injuries. Patient was discharged home the next day. No other documentation to indicate that the clinician considered the CKD as an issue during the admission.

Principal diagnosis: Head injury

Additional diagnosis: Laceration of forehead

Contusion of abdominal wall

External cause of injury

Place of occurrence

Activity

In this example, the pre-existing CKD is not a significant condition in the episode of care, as it only resulted in a minor adjustment to the diagnostic work-up for the injuries (non-contrast CT scan instead of contrast CT scan). No clinical consultation or care plan was undertaken for the CKD; therefore, it does not meet the criteria in ACS 0002. Assign U87.1 *Chronic kidney disease, stage 3-5* for the CKD (see ACS 0003 *Supplementary codes for chronic conditions*).

**EXAMPLE 9:**

A 61-year-old man with a history of hypertension and chronic kidney disease (CKD) was admitted with a non-ST elevation myocardial infarction (NSTEMI) and acute pulmonary oedema. Patient was treated with BiPAP, GTN infusion and underwent preparation for a coronary angiogram. Prior to the intervention, a renal physician was consulted regarding the patient's kidney function and noted that "Creatinine 140 and eGFR 45. Risk of contrast nephropathy is relatively low given eGFR is more than 30. Patient needs to be monitored for fluid status and UEC, suggest pre and post intervention hydration".

Principal diagnosis: Non-ST elevation myocardial infarction

Additional diagnosis: Left ventricular failure  
Chronic kidney disease, stage 3

In this example, the pre-existing CKD meets the criteria in ACS 0002 in the episode of care, as clinical consultation was undertaken resulting in a care plan for the CKD. Assign U82.3 *Hypertension* for the hypertension (see ACS 0003 *Supplementary codes for chronic conditions*).

**EXAMPLE 10:**

A patient was admitted for elective left total hip replacement for osteoarthritis. Prior to the operation, the anaesthetic team requested an Intensivist to assess the patient. Consultation noted "known to have severe OSA, on CPAP for four months. CCF with left ventricle ejective fraction (LVEF) of 40%. Risk of developing cardiac or respiratory complications is very high, needs ICU admission post-operation and troponin test. Postoperative hypotension is very likely given biventricular failure". Patient was transferred to ICU after surgery and extubated on the second day. She was treated with BiPAP, Lasix, and chest physiotherapy in addition to other routine post-operative management.

Principal diagnosis: Osteoarthritis

Additional diagnosis: Congestive heart failure  
Obstructive sleep apnoea

In this example, the pre-existing congestive heart failure and obstructive sleep apnoea both meet the criteria in ACS 0002 in the episode of care, as these conditions resulted in a major variation to the care plan following the Intensivist consultation ('needs ICU admission after hip replacement').

**EXAMPLE 11:**

Patient was admitted for febrile neutropenia and reduced oral intake secondary to chemotherapy for left breast cancer. Patient was advised by a nurse to drink more fluids as slightly hypotensive.

Principal diagnosis: Neutropenia

Additional diagnosis: Drug-induced fever  
Adverse effect from chemotherapy  
Breast cancer  
Morphology code for breast cancer

In this example, the hypotension was not a condition that significantly affected patient management in the episode of care. The patient was only advised to drink more fluids. There was no diagnostic or therapeutic treatment/intervention undertaken, and no care plan was prescribed. Therefore, it does not meet the criteria in ACS 0002. Assign codes for the breast cancer as per the guidelines in ACS 0236 *Neoplasm coding and sequencing*.

**EXAMPLE 12:**

An 84-year-old female was admitted after a fall. CT scan of head, neck and chest revealed multiple fracture of ribs (4-7) on the left side of chest, which were treated conservatively. Her past medical history included ischaemic heart disease, hypertension, chronic obstructive pulmonary disease (COPD) and falls. On arrival, the patient was examined by the registered nurse, who diagnosed and documented a stage I pressure injury (PI) on the left heel. A wound care treatment plan was commenced.

Principal diagnosis: Fractures of multiple ribs  
Additional diagnosis: External cause of injury  
Place of occurrence  
Activity  
Pressure injury, stage I, heel

In this example, the pressure injury meets the criteria in ACS 0002 in the episode of care. The PI was assessed and diagnosed by a registered nurse, and a treatment plan was commenced specifically for the condition. Assessment and diagnosis of the PI is within the scope of nursing practice. Assign U82.3 *Hypertension* for the hypertension, U82.1 *Ischaemic heart disease* for the ischaemic heart disease and U83.2 *Chronic obstructive pulmonary disease* for the COPD (see ACS 0003 *Supplementary codes for chronic conditions*).

**DIAGNOSTIC PROCEDURES**

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 (eg 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 (see Examples 14, 15 & 16).

**EXAMPLE 13:**

Patient with chronic kidney disease (CKD), stage 3 was admitted for a hip hemiarthroplasty for treatment of a femoral neck fracture. Routine day 1 and day 2 postoperative blood tests revealed the patient's haemoglobin (Hb) levels were slightly below the normal range and kidney function tests (KFTs) were stable. No further investigations or interventions were undertaken during the episode, but on discharge the patient was referred to his general practitioner to follow-up the Hb level and CKD.

Principal diagnosis: Femoral neck fracture  
Additional diagnosis: External cause of injury  
Place of occurrence  
Activity

In this example, the slightly decreased Hb levels and KFTs were obtained from routine post-operative monitoring and there were no further investigations or interventions undertaken during the episode of care for these conditions; therefore, they do not meet the criteria in ACS 0002. Assign U87.1 *Chronic kidney disease, stage 3-5* for the CKD (see ACS 0003 *Supplementary codes for chronic conditions*).

**EXAMPLE 14:**

An elderly patient was admitted with per rectal bleeding. A diagnostic sigmoidoscopy was performed, which confirmed rectal cancer. On admission, routine blood tests showed that the patient's haemoglobin (Hb) level was 79 g/L. Day 2 progress notes stated "Hb 79, anaemia is likely due to low gastrointestinal bleeding, repeat FBC, EUC for next two days".

Principal diagnosis: Rectal cancer

Additional diagnosis: Anaemia secondary to blood loss

In this example, the repeat FBC (including Hb) was specifically ordered by a clinician to confirm the diagnosis of anaemia. Therefore, the anaemia meets the criteria in ACS 0002 in this episode of care.

**EXAMPLE 15:**

A 36-year-old obese woman was admitted for a laparoscopic sleeve gastrectomy. During the admission, the patient reported a dull headache accompanied by numbness in the left side of her face. She described the headache as different from her usual migraine attacks and not responding to sumatriptan (self medication). A CT scan brain was ordered, which did not reveal any abnormality.

Principal diagnosis: Obesity

Additional diagnosis: Headache

In this example, the headache meets the criteria in ACS 0002, as a CT scan of the brain was specifically ordered to investigate the cause of headache (ie the condition required further investigation).

**EXAMPLE 16:**

An 88-year-old woman presented to hospital with increasing shortness of breath secondary to an exacerbation of congestive heart failure (CCF) and asthma. Routine admission screening for ARO (Antibiotic Resistant Organisms) identified that she was MRSA (Methicillin Resistant Staphylococcus Aureus) positive. The infection control team ordered implementation of contact precautions and she remained in single room isolation. Her CCF and asthma responded well to treatment with nebulised salbutamol and diuresis.

Principal diagnosis: Congestive heart failure

Additional diagnosis: Asthma

Carrier of other specified bacterial diseases

Resistance to methicillin

In this example, although ARO screening was routine, the positive MRSA status meets the criteria in ACS 0002 in the episode of care, as there was an infection control protocol implemented for the patient.

**INCREASED CLINICAL CARE**

**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 (eg urinary and bowel), pressure area prevention and skin care, assisting with activities of daily living and mobilisation (see Example 17)
- 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) (see Example 13)
- assessment of pre-existing conditions without a documented care plan specifically for these conditions (eg 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 and management of pain levels and bowel function, deep venous thrombosis and pressure injury prophylaxis (see Example 19)

**Conditions are significant** in an episode of care when clinical care provided for a condition is beyond routine (ie **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 (eg 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 (eg 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 (see Examples 12, 21 & 22)

- performance of a therapeutic treatment/intervention for a condition (see also ACS 0002 *Additional diagnoses/Commencement, alteration or adjustment of therapeutic treatment*) (see Examples 4, 5, 6 & 7)
- pre and postoperative management in excess of routine care (see also ACS 1904 *Procedural complications*) (see Examples 18 & 20)

#### **EXAMPLE 17:**

An 86-year-old man was admitted with community acquired pneumonia. Patient had a long history of urinary incontinence. During the admission, his incontinence pads were changed regularly and zinc oxide cream applied daily to his skin, by the nurse.

Principal diagnosis:           Pneumonia

In this example, the urinary incontinence is not a condition that significantly affected patient management in this episode of care. Daily topical application of zinc oxide cream is general nursing care for this condition; therefore, it does not meet the criteria in ACS 0002.

#### **EXAMPLE 18:**

Patient admitted for laparoscopic hysterectomy for a thickened endometrium. Postoperatively the patient reported repeated incidences of involuntary passage of urine since the removal of an indwelling catheter. The clinical team assessed the patient and noted in the progress notes, “Developed urinary incontinence 2 days post hysterectomy. Patient denied dysuria, haematuria, faecal incontinence or history of urinary incontinence. Risk factors: overweight, menopause, and post-hysterectomy. Physical examinations including neurological screening were unremarkable. Plan: blood and urinalysis to rule out urinary tract infection; bladder ultrasound scan to measure post-void residual urine; strict input/output record and continence chart; nurse to assist with toileting; urological referral if problem persists”. Urinalysis was negative for urinary tract infection. Ultrasound estimation of post-void residual urine was negligible. Patient’s symptoms were largely resolved at discharge.

Principal diagnosis:           Thickened endometrium

Additional diagnosis:        Urinary incontinence

In this example, the urinary incontinence meets the criteria in ACS 0002 in the episode care, as clinical consultation was undertaken and diagnostic procedures were performed.

**EXAMPLE 19:**

A 77-year-old man was admitted for a repair of an inguinal hernia. Day 2 postoperative progress notes: “constipation – aperients given”. Day 3 postoperative nursing notes: “diarrhoea due to aperients overload and aperients withheld”. No further investigations undertaken during the episode.

Principal diagnosis:           Inguinal hernia

In this example, the monitoring and management of bowel function during the postoperative period is routine care and withholding aperients is a nurse-initiated intervention; therefore, neither constipation nor diarrhoea meet the criteria in ACS 0002 in the episode of care.

**EXAMPLE 20:**

An elderly patient was admitted for cholecystectomy for chronic cholecystitis. Day 3 post cholecystectomy progress notes: “patient reported ongoing abdominal pain and no bowel motions for the previous three days, despite administration of laxatives”. Physical examinations revealed a distended abdomen with a firm, large bloated appearance. Abdominal x-ray confirmed no bowel obstruction, but a large amount of faecal material was seen in the large bowel. Fleet enemas were charted to relieve the constipation.

Principal diagnosis:           Chronic cholecystitis

Additional diagnosis:        Constipation

In this example, the constipation is a significant condition during the episode of care, as it required investigation (ie abdominal x-ray) and an intervention was undertaken; therefore, it meets the criteria in ACS 0002.

**EXAMPLE 21:**

Patient with metastatic endometrial cancer was admitted for unstable angina. During the hospital stay, the patient developed per-vaginal (PV) bleeding, secondary to her endometrial cancer. A radiation oncologist was consulted over the phone for advice on whether urgent radiation therapy was required. Documentation indicated that the radiation oncologist advised that the patient had been assessed as unsuitable for radiation therapy.

Principal diagnosis:        Unstable angina

Additional diagnosis:        Endometrial cancer

Morphology code for endometrial cancer

In this example, the endometrial cancer meets the criteria in ACS 0002 in the episode of care, as clinical consultation was undertaken specifically for the condition (*Note:* Telephone consultation with clear documentation of the information exchange is regarded as clinical consultation).

**EXAMPLE 22:**

A 55-year-old man presented with lower respiratory infection exacerbating his chronic obstructive pulmonary disease. He was commenced on Bactrim BD and physiotherapy performed. On the second day of the admission, the patient complained of having chest tightness since arrival to the hospital. He described the pain as constant, but not radiating. Nurse consulted the treating clinician over the phone and documented “team doctor advised over the phone to administer PRN GTN 300mcg. ECG was performed. Patient states that pain was not relieved with PRN oral GTN, so was given further GTN 300mcg as per team instruction. Patient remains saturating well and telemetry is in situ”. Patient responded well to the treatment and was discharged.

Principal diagnosis:        Chronic obstructive pulmonary disease with acute lower respiratory infection

Additional diagnosis:        Chest pain

In this example, the chest pain meets the criteria in ACS 0002 in the episode of care, as clinical consultation was undertaken specifically for the condition (*Note:* Telephone consultation with clear documentation of the information exchange is regarded as clinical consultation).