



Government of **Western Australia**
Department of **Health**

Preview of Twelfth Edition Changes

ACS 0010 Clinical documentation and general abstraction guidelines

WA Clinical Coding Authority

Purchasing and System Performance Division

Published May 2022, updated June 2022

Produced with resources available prior to release of IHPA Education

The **intent** of ACS 0010 *Clinical documentation and general abstraction guidelines* **has not changed for 12th Edition** but it's undergone a wording and formatting refinement to clarify and reinforce:

- clinician and coder responsibilities.
- **the focus of the standard is about abstraction.**
- the sections of a record that can be used to inform code assignment for the current episode.

NEW

ACS 0010 is now primarily a guide for coder abstraction

Clinician documentation responsibilities are now detailed in:
Action 6.11 Documentation of information in the Communicating for Safety Standard by the Australian Commission on Safety and Quality in Health Care
[Action 6.11 | Australian Commission on Safety and Quality in Health Care](#)

Notable wording and formatting changes:

- Relocating content between the ACS *Introduction* and ACS 0010.
- Defining the following ACS 0010 terms in a newly created ACS *Glossary of terms*:
 - Admitted patient stay
 - Clinician
 - Episode of care
 - Health care record
 - Scope of practice
- Relocating and renaming query guidelines to ACS Appendix B: *Guidelines for formulating clinical documentation queries*.

NEW

 IHPA education should address the concept 'Admitted patient stay'

A summarised refresher of the core concepts of ACS 0010 *Clinical documentation and general abstraction guidelines*, with reference to its refined wording, follows.

Summarised excerpt from the new ACS Glossary of terms

Term	Description
Admitted Patient stay	<ul style="list-style-type: none"> ▪ Period of admitted care between formal admission and formal separation. ▪ Contains one or more admitted episodes. ▪ May involve a Care Type change. ▪ May include contracted or hospital-in-the-home care.
Clinician	<ul style="list-style-type: none"> ▪ Refers to: <ul style="list-style-type: none"> ○ the treating medical or surgical clinician ○ anaesthetists ○ other consulting health professionals who document in the health care record. ○ allied health professionals ○ midwives ○ nurses <p style="text-align: center;">See also National Coding Advice Q3579.</p>
Episode Of care	<ul style="list-style-type: none"> ▪ Period of admitted care between formal or statistical admission and formal or statistical separation. ▪ Characterised by one care type. ▪ Occurs in hospital and/or as hospital-in-the-home care.
Health Care record	<ul style="list-style-type: none"> ▪ Can be paper, electronic, both (hybrid). ▪ Includes: <ul style="list-style-type: none"> ○ care plans ○ handover notes ○ checklists ○ pathology results ○ operation reports ○ discharge summaries ▪ Content will vary and reflect the documentation appropriate to each health service.



Summarised excerpt from the new ACS Glossary of terms (cont.)

Term	Description
Scope Of practice	<ul style="list-style-type: none"> ▪ Defined by the health service organisation. ▪ Dependent on the practitioner operating within the bounds of their qualifications, education, training, current experience and competence, and within the capability of the facility or service in which they are working. ▪ Clinicians document clinical findings, decisions and actions in the health care record within their scope of practice.

NEW

Aspects of clinical documentation, such as scope of practice, requires coordination at the local level for a **hospital** to align with practices that are observed within that **facility**.

(as per IHPA during the ITG process)

 IHPA education should include more examples demonstrating Scope of practice

Q3579 CLARIFICATION OF NURSING SCOPE OF PRACTICE AND USE OF NURSING DOCUMENTATION TO INFORM CODE ASSIGNMENT

(effective 1 Jan 2021)

It is impractical to define the scope of practice of every clinician, particularly nursing, because of the wide variability in practice across metropolitan and rural regions, jurisdictions, clinical settings and governance policies.

Ultimately, responsibility for documentation lies with the treating clinician. Nursing documentation is not precluded from informing code assignment. In particular, specialist nurses, midwives, diabetes educators, mental health nurses, lactation consultants and wound consultants will document within the scope of their practice, problems and conditions that may or may not be documented by the treating medical officer.

Nursing documentation has the potential to provide specificity but needs to be balanced against what is corroborated in the clinical episode as a whole and must not rely on patient completed forms.

For further information on Scope of practice, see: *Credentialing and defining scope of clinical practice: A guide for managers and clinicians*, a consultation paper by the Commission on Safety and Quality in Health care.

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/draft-credentialing-and-defining-scope-clinical-practice-guide-managers-and-clinicians>

Responsibilities

Treating clinician documentation responsibilities are:

- accuracy
- specificity
- listing the episode's principal and additional diagnoses, and interventions on the discharge summary.

Coder responsibilities are:

- verifying concepts on the discharge summary with documentation in the current episode, prior to assigning codes.
- being familiar with their organisation's health information systems to understand how documents relate to the current episode (this responsibility is now explicit in 12th Ed. ACS 0010). 
- not presuming conditions that aren't supported by documentation.

Clinical documentation queries are to be sent when:

- an episode's documentation is insufficient for coding, such as when it:
 - is ambiguous, conflicting, illegible or lacking specificity.
 - includes findings, diagnostic evaluation and/or treatment not related to a specific documented condition or intervention.
 - is unclear for condition onset flag assignment.

and

- reference to documentation outside the current episode does not answer the query.

 See also Appendix B *Guidelines for formulating clinical documentation queries*.

Abstraction guidelines

1. Documentation for classification is:

- primarily located in the current episode.
- primarily by medical/surgical clinicians.
- by other clinicians (ie specialist nurses, midwives, allied health)* where it's appropriate to their scope of practice. *This list is not exhaustive.

○ See also Scope of practice in ACS *Glossary of terms* and National Coding Advice Q3579.

2. 'Other' sections in the record:

- past episodes
- referral letters
- other correspondence
- emergency department notes
- test results
- outpatient notes
- documentation of care provided at another health service

are considered to be **documentation outside of the current episode** and can be accessed for:

- **clarifying** ambiguous documentation in the current episode.
- gaining **specificity** on conditions documented in the current episode.
- **determining** the reason for admission.

SECONDARY (METASTATIC) NEOPLASMS

NEW

Codes for secondary/metastatic neoplasms are only assigned if the secondary/metastatic site is documented by the clinician in the current episode (per ACS 0236 *Neoplasm coding and sequencing*). The secondary/metastatic site does not itself have to meet ACS 0002 criteria for code assignment. Abstracting secondary/metastatic site information from documentation outside of the current episode is considered abstracting for 'severity' rather than abstracting for 'specificity.' For more information, see *Question awaiting clarification from IHPA education*, later in this document. See also, examples 1-3.

3. When there's a **single discharge summary for more than one episode**:

NEW

- it can be abstracted from to code all episodes within the specified dates.
 - the codes assigned for each episode must meet ACS 0001, ACS 0002 or a speciality standard.
- Note: if a condition has resolved in one episode, it shouldn't be coded in a subsequent episode.

4. When there's a **single referral for multiple same-day episodes for repeated treatments**, the referral's information can be used to code all related episodes of care (e.g. same-day episodes for pharmacotherapy).

5. When there are **multiple episodes in an admitted patient stay**:

- these mandatory conditions may be carried forward and coded for latter episodes: **NEW**

Condition	Relevant ACS
Chronic conditions	0003 <i>Supplementary codes for chronic conditions</i>
HIV/AIDS	0102 HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome)
Viral hepatitis	0104 <i>Viral hepatitis</i>
History of COVID-19	0113 <i>Coronavirus disease 2019 (COVID-19)</i>
Diabetes mellitus and intermediate hyperglycaemia	0401 <i>Diabetes mellitus and intermediate hyperglycaemia</i>
Tobacco use disorders	0503 <i>Drug, alcohol and tobacco use disorders</i>
Exposure to tobacco smoke	2118 <i>Exposure to tobacco smoke</i>
Socioeconomic and psychosocial factors	2119 <i>Socioeconomic and psychosocial circumstances</i>

Note:

- This guideline is not mandatory. These conditions **may** be carried forward and coded for latter episodes, when it's practical to do so:
 - Where a single coder, classifies multiple sequential episode for an admitted patient stay, it may be practical for them to carry codes for such conditions forward and assign them for one episode to the next.
 - Where multiple coders, classify the individual episodes for an admitted patient stay, or where the record is volumised, carrying codes forward may be impractical.
- Specialty standards for these conditions instruct they're to be **coded when documented** by a clinician (as per IHPA during ITG process). Clinicians include medical officers, midwives, nurses, allied health professionals (see also Clinician in *ACS Glossary of terms* and National Coding Advice Q3579).
- These conditions can't be abstracted from Emergency Department documentation and coded as additional diagnoses for a later admitted episode (as per IHPA during ITG process).
- See examples 4 and 5.

6. Documentation of test result values and descriptions:

- can be used to inform code assignment where it adds specificity to conditions already documented in the current episode.
- must be qualified by other documentation in the current episode.
- can't be use in isolation to assign codes, ie:
 - Test results outside the normal range do not necessarily mean a patient has an abnormal condition - they may be normal for that patient.
 - Documented descriptions (eg low potassium levels) do not necessarily mean a patient has a condition (eg hypokalaemia).

7. Documentation on medication charts:

- can be used to inform code assignment where it adds specificity to conditions already documented in the current episode.
- must be qualified with documentation in the current episode.
- can't be use in isolation to assign codes, ie:
 - Drugs may be administered for a variety of indications, including for prophylaxis.
 - A documented indication for a drug on a medication chart must be qualified within the body of the current episode.
- See example 6.

8. Documented components of health risk screening (assessment) tools: **NEW**

- are not considered diagnoses for classification purposes.
- can't be used in isolation to assign codes.
- Eg Malnutrition Universal Screening Tool (MUST).
- See examples 7 and 8.

9. When shorthand is documented in relation to conditions or findings: **NEW**

- Egs arrows →↓↑, slashes /, less and greater than symbols <>.
- it's used to describe the causal relationship between two conditions, eg emphysema/smoker.
- determine if it sufficiently describes a causal relationship, or
- qualify the shorthand with more specific documentation in the current episode, or
- seek clarification to determine if a causal relationship between two conditions exists, if it's unclear in the documentation.
- If documentation doesn't sufficiently describe a diagnosis, assign a code for the condition represented in shorthand only if:
 - a) test results (eg pathology report) verify that a result is abnormal, and
 - b) there is appropriate indexing, and
 - c) it meets the criteria in ACS 0001 or ACS 0002.
- If there's no appropriate lead term in the Index (eg high, low, depletion), or there's ambiguity in the documentation, clarify the significance of the shorthand with the clinician, before assigning a code.
- Avoid using lead terms from shorthand that describe a diagnosis rather than an abnormal result, eg. don't use the lead term 'deficiency' where shorthand only indicates a low test result.

NEW for 12th Edition

For '↓ K'

**follow Indexed Lead
term 'Depletion' to
assign E87.6
*Hypokalaemia***

10. When test results vary from a documented condition, and the relationship between the conflicting test result and the condition is unclear:

- Best practice is to send a clinical documentation query.
 - If an answer to the query is not forthcoming, assign a code for the documented condition.
 - Note: test results that vary from a documented condition, are expected for some conditions, eg Crohn's disease not detected on intestinal biopsy. A query may not be necessary in such circumstances.
- Where documentation for the episode of care does not verify the relationship between a test result and a condition, clarification should be sought. Where this is not possible, the documentation should take precedence over the test results (as per IHPA during the ITG process).
- Observation results such as BP (blood pressure) and BSL (blood sugar level) are considered under the broader umbrella term of 'test results' (as per IHPA during ITG process).
- The broader term of 'test results' includes findings (as per IHPA during the ITG process).

11. When there are test results with an unclear or no associated condition documented:

- don't use them to determine code assignment when:
 - there's no documentation in the record to indicate the significance of the test result, or
 - there's an unclear relationship between the test result and a condition.

Question awaiting clarification from IHPA education

Paraphrased question

This question was asked during the ITG process for development of 12th Ed. ACS 0206 and ACS 0236: Is documentation of "met" (in the current episode) enough to apply ACS 0010 and refer to documentation outside of the episode, to determine and code specific metastatic sites; or do coders assign C79.9 *Secondary malignant neoplasm, unspecified site* for such documentation?

WACCA

This question was not addressed by IHPA during the ITG process. If "metastatic breast cancer" is the principal diagnosis for same-day chemotherapy episodes, are coders allowed to abstract from outside of the current episode to find the metastatic sites; or do they assign C79.9 for the documentation "metastatic"? ACS 0236 is quite specific, i.e. assign code(s) for secondary (metastatic) sites that are documented by the clinician in the current episode. ACS 0236 is a specialty standard, so does the ACS 0236 instruction override ACS 0010? In short, can, and when, can a coder apply the guidelines in ACS 0010 to abstract and code metastatic neoplasm sites?

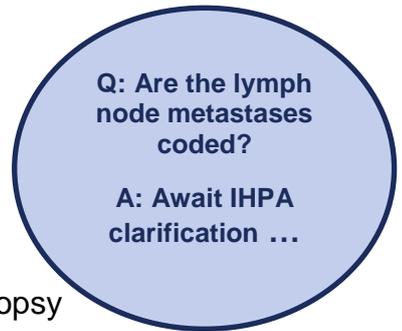
Examples

Example 1 – Metastatic neoplasm sites

Discharge summary for 15 July – 16 July completed on 16 July
Principal diagnosis: Breast cancer
Principal procedure: Excision of lesion and sentinel lymph node biopsy

Histopathology results reported on 18 July
Breast cancer, lymph node metastases

This episode is a short stay admission, so there's no documentation of lymph node involvement and/or 'metastatic breast cancer' on the discharge summary or in the body of the current episode.



Example 2 – Metastatic neoplasm sites

Discharge summary for 15 July – 30 July
Principal diagnosis: Breast cancer metastatic to brain – palliative

Integrated progress notes on 15 July
Impression: Breast cancer metastatic to brain
Plan: For palliation

Whole body CT scan on 1 May
Breast cancer with brain and bony metastases

Code assignment in 12th Edition

Assign

Codes for the primary neoplasm (breast)
Codes for the metastatic neoplasm documented in the current episode (brain)

Do not assign

Codes for the metastatic neoplasm documented outside of the current episode (bone)

Rationale

As per ACS 0236 *Neoplasm coding and sequencing*, only assign codes for metastatic sites that are documented by the clinician in the current episode.

Example 3 – Metastatic neoplasm sites documented outside of the current episode

Documentation of colon cancer (meeting coding criteria) in the current episode. Metastatic neoplasm sites documented in previous episodes only.

Code assignment in 12 th Edition	
Assign Codes for the primary neoplasm - colon	
Do not assign Codes for the metastatic neoplasms	
Rationale As per ACS 0236 <i>Neoplasm coding and sequencing</i> , <u>only</u> assign codes for metastatic sites that are documented by the clinician in the current episode.	

Example 4 – Multiple episodes in an admitted patient stay

Admitted patient stay consisting of an Acute, followed by a Palliative Care Type episode. In the Acute episode 'ex-smoker approx.12 months' is documented by the treating clinician. Documentation of 'ex-smoker' is not repeated in the Palliative episode. A single coder classifies the Acute and Palliative episodes, one after the other, in one sitting.

Code assignment in 12 th Edition	
Code assignment for Acute episode	Code assignment for Palliative episode
Assign Z86.43 <i>Personal history of tobacco use disorder</i>	Assign Z86.43 <i>Personal history of tobacco use disorder</i>
Rationale As per ACS 0503 <i>Drug, alcohol and tobacco use disorders</i> , Z86.43 is assigned where there's documentation a patient has consumed tobacco in the past, excluding the previous month.	Rationale As per ACS 0010 12 th Ed., when there are multiple episodes in an admitted patient stay, codes for mandatory conditions may be carried forward and assigned for latter episodes. In this example, it's practical for the single coder to do so.

Example 5 – Multiple episodes in an admitted patient stay

Admitted patient stay consisting of a Rehabilitation, then Acute, then another Rehabilitation Care Type episode. In the Acute episode ‘ex-smoker approx.12 months’ is documented by the treating clinician. Documentation of ‘ex-smoker’ is not repeated in either of the Rehabilitation episodes. A single coder classifies all episodes, one after the other, in one sitting.

Code assignment for 1 st Rehabilitation episode	Code assignment in 12 th Edition Code assignment for Acute episode	Code assignment for 2 nd Rehabilitation episode
<p>Do not assign Z86.43 <i>Personal history of tobacco use disorder</i></p> <p>Rationale As per ACS 0010 12th Ed., when there are multiple episodes in an admitted patient stay, codes for mandatory conditions may be carried forward and assigned for latter episodes. Codes for mandatory conditions are not carried backward and assigned for earlier episodes.</p>	<p>Assign Z86.43 <i>Personal history of tobacco use disorder</i></p> <p>Rationale As per ACS 0503 <i>Drug, alcohol and tobacco use disorders</i>, Z86.43 is assigned where there’s documentation a patient has consumed tobacco in the past, excluding the previous month.</p>	<p>Assign Z86.43 <i>Personal history of tobacco use disorder</i></p> <p>Rationale As per ACS 0010 12th Ed., when there are multiple episodes in an admitted patient stay, codes for mandatory conditions may be carried forward and assigned for latter episodes. In this example, it’s practical for the single coder to do so.</p>

Example 6 – Documentation on medication charts

Patient admitted for treatment of pneumonia.

Medication chart

Indication: ‘Hypokalaemia’ Prescription: ‘Slow-K’

There is no documentation of ‘hypokalaemia’ or potassium results in the body of the current episode of care.

Code assignment in 12 th Edition
<p>Assign Principal diagnosis: J18.9 <i>Pneumonia, unspecified</i></p> <p>Do not assign Additional diagnosis: E87.6 <i>Hypokalaemia</i></p> <p>Rationale As per ACS 0010 12th Ed. documentation on medication charts can’t be use in isolation to assign codes. A documented indication for a drug on a medication chart must be qualified within the body of the current episode.</p>

Version History

Version	Date released	Author	Amendment
1.0	May 2022	WA Clinical Coding Authority	
1.1	June 2022	WA Clinical Coding Authority	'Admitted hospital stay' replaced with 'Admitted patient stay' as per Errata 1, effective 1 July 2022

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