IHACPA

AUSTRALIAN CODING STANDARDS FOR ICD-10-AM AND ACHI

THE INTERNATIONAL STATISTICAL CLASSIFICATION
OF DISEASES AND RELATED HEALTH PROBLEMS,
TENTH REVISION, AUSTRALIAN MODIFICATION

THE AUSTRALIAN CLASSIFICATION OF HEALTH INTERVENTIONS

THIRTEENTH EDITION
1 JULY 2025

INDEPENDENT HEALTH AND AGED CARE PRICING AUTHORITY

TABLE OF CONTENTS

ABBREVIATIONS

The following is a non-exhaustive list of non-clinical abbreviations, acronyms and initialisms found in the *Australian Coding Standards*:

ACE	Australian Classification Exchange
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standard(s)
AIHW	Australian Institute of Health and Welfare
APC NMDS	Admitted Patient Care National Minimum Data Set
AR-DRG	Australian Refined Diagnosis Related Groups
ASA	American Society of Anesthesiologists
CCAG	Classifications Clinical Advisory Group
CCSA	Clinical Coders' Society of Australia
CDIS	Clinical Documentation Improvement Specialist
CDS	Clinical Documentation Specialist
COF	Condition onset flag
DCID	Diagnosis cluster identifier
DTG	Diagnosis Related Groups Technical Group
HIMAA	Health Information Management Association of Australia
ICD	International Statistical Classification of Diseases
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
IHPA	Independent Hospital Pricing Authority
IHACPA	Independent Health and Aged Care Pricing Authority
ITG	International Classification of Diseases Technical Group
MBS	Medicare Benefits Schedule
NASPE	North American Society of Pacing and Electrophysiology
NEC	Not elsewhere classified
NHRA	National Health Reform Agreement
NMDS	National Minimum Data Set
NOS	Not otherwise specified
The Commission	Australian Commission on Safety and Quality in Health Care
WHO	World Health Organization

GENERAL STANDARDS FOR ICD-10-AM

0001 PRINCIPAL DIAGNOSIS

For guidance regarding:

- residual condition or nature of sequelae — see ACS 0008 *Sequelae*
- intervention cancelled or not performed — see ACS 0011 *Intervention cancelled or not performed*
- suspected conditions — see ACS 0012 *Suspected conditions*
- principal diagnosis in obstetric episodes of care — see ACS Chapter 15 *Pregnancy, childbirth and the puerperium*
- multiple injuries — see ACS 1907 *Multiple traumatic injuries.*

Description(s)

Principal diagnosis is:

> *"The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code"* (AIHW 2024e).

1. PRINCIPAL DIAGNOSIS

Directive(s)

1.1 Assign as principal diagnosis, the condition that is established after study to be chiefly responsible for occasioning the episode of care (see Example 1).

Exception(s)

1. **Do not** assign as principal diagnosis, codes referred to in the following *General standards for ICD-10-AM*:
   - ACS 0049 *ICD-10-AM codes that must never be assigned*
   - ACS 0050 *Unacceptable principal diagnosis codes.*

Note(s)

1. The phrase **after study** in the definition means evaluation of findings to establish the condition that was **chiefly responsible for occasioning the episode of care**. Findings evaluated may include information gained from the history of illness, mental health status evaluation, specialist consultations, physical examination, diagnostic tests or interventions, surgical interventions, and any pathological or radiological examination. The condition established after study may or may not confirm the admitting diagnosis.

   The circumstances of an episode of care will always govern the selection of principal diagnosis. In determining principal diagnosis, the coding directives in ICD-10-AM Tabular List and Alphabetic Index take precedence over all other guidelines (see ICD-10-AM Tabular List: *Conventions used in the ICD-10-AM Tabular List* and ICD-10-AM Alphabetic Index: *Conventions used in the ICD-10-AM Alphabetic Index*).

Example 1:

Patient was admitted with the following diagnoses listed on the front sheet and discharge summary (supported by documentation in the clinical notes):

Diabetes mellitus
Coronary artery disease
Myocardial infarction

History of present illness: Patient experienced severe chest pain on the morning of admission and was transported by ambulance to hospital and admitted to the coronary care unit for treatment of a myocardial infarction.

Assign: Principal diagnosis: Myocardial infarction

Rationale: Myocardial infarction — for the condition that was established after study to be chiefly responsible for occasioning the episode of care (*Directive* 1.1)

2. AETIOLOGY AND MANIFESTATION CONVENTION (THE 'DAGGER AND ASTERISK' SYSTEM)

0001

Directive(s)

2.1 Sequence either the aetiology (dagger) or manifestation (asterisk) code as principal diagnosis, for the condition that meets the principal diagnosis definition.

Note(s)

2. Dagger and asterisk pairs are always listed in the Alphabetic Index with the dagger (aetiology) code sequenced first, however, either code can be assigned as the principal diagnosis.

3. PROBLEMS AND UNDERLYING CONDITIONS

3.1 Coding the underlying condition as the principal diagnosis

Directive(s)

3.1.1 Assign a code for the underlying condition as the principal diagnosis where a problem is the reason for admission and during the episode of care the underlying condition (cause) is identified (see Example 2).

3.1.2 **Do not** assign a code for the problem (see Example 2).

Example 2:

Patient was admitted with seizures. The patient had not previously been treated for seizures. Computerised tomography revealed a large brain tumour as the cause of the seizures.

Assign: Principal diagnosis: Brain tumour

Rationale: Brain tumour — for the underlying cause of the seizures (*Directive* 3.1.1)

An additional diagnosis code is **not** assigned for the problem (seizures) as the underlying condition was identified during the episode of care (*Directive* 3.1.2).

3.2 Coding the problem as the principal diagnosis

Directive(s)

3.2.1 Assign a code for the problem as principal diagnosis where it is the reason for admission and the underlying condition (cause) is known at the time of admission but **only** the problem is treated (see Examples 3 and 4).

3.2.2 Assign an additional diagnosis code for the underlying condition (see Examples 3 and 4).

Example 3:

Patient was admitted for treatment of recurrent seizures caused by a brain tumour diagnosed three months previously.

Assign: Principal diagnosis: Seizures

Additional diagnosis: Brain tumour

Rationale: Seizures — for the problem, as the underlying condition was not being treated (*Directive* 3.2.1)

Brain tumour — for the underlying condition (*Directive* 3.2.2)

Example 4:

Patient was admitted for drainage of ascites due to known underlying liver disease.

Assign: Principal diagnosis: Ascites

Additional diagnosis: Liver disease

Rationale: Ascites — for the problem, as the underlying condition was not being treated (*Directive* 3.2.1)

Liver disease — for the underlying condition (*Directive* 3.2.2)

4. SYMPTOMS, SIGNS AND ILL-DEFINED CONDITIONS

Directive(s)

4.1 **Do not** assign codes for symptoms, signs and ill-defined conditions classified to Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)* as principal diagnosis when a related definitive diagnosis has been established.

See also the *Note* at the beginning of Chapter 18.

5. ACUTE ON CHRONIC CONDITIONS

Directive(s)

5.1 Assign codes for both the acute (subacute) and chronic conditions, where a condition is described as both acute (subacute) and chronic, and has separate subterms in the Alphabetic Index at the same indentation level (see Example 5).

5.2 Sequence the code for the acute (subacute) condition first (see Example 5).

Exception(s)

2. **Do not** apply *Directives* 5.1 and 5.2 where the:
   - Tabular List has an instruction to the contrary (see Example 6) **or**
   - Alphabetic Index indicates that only one code is required (see Example 7).

Example 5:

Patient was admitted for acute on chronic pancreatitis.

Index: **Pancreatitis**
- acute (recurrent) K85.9
…
- chronic (infectious) K86.1
…

Assign: Principal diagnosis: Acute pancreatitis
Additional diagnosis: Chronic pancreatitis

Rationale: Acute pancreatitis — for the acute condition (acute on chronic), with separate subterms in the Alphabetic Index at the same indentation level (*Directive* 5.1) and sequenced first (*Directive* 5.2)
Chronic pancreatitis — for the chronic condition (acute on chronic) (*Directive* 5.1)

Example 6:

Patient was admitted with acute on chronic myeloid leukaemia.

Tabular List: **C92.0** **Acute myeloblastic leukaemia [AML]**
Excludes: acute exacerbation of chronic myeloid leukaemia (C92.1-)

Assign: C92.1- *Chronic myeloid leukaemia [CML], BCR/ABL-positive*

Rationale: C92.1- — for acute on chronic myeloid leukaemia, as per the *Excludes* note in subcategory C92.0 (*Exception* 2)

Example 7:

Patient was admitted with acute on chronic bronchiolitis.

Index: **Bronchiolitis** (acute) (infective) (subacute) J21.9
- chronic (fibrosing) J44.8

Assign: J44.8 *Other specified chronic obstructive pulmonary disease*

Rationale: J44.8 — as per the Alphabetic Index, as ‘acute’ is a nonessential modifier and ‘chronic’ is listed as a subterm. Therefore, acute bronchiolitis is inherent in J44.8 and does **not** require a separate (additional) code assigned (*Exception* 2)