The following Technical Bulletin is for distribution to all public hospitals:

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Supersedes</th>
<th>Enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>43/3</td>
<td>WA Coding Standards</td>
<td>43/2</td>
<td>William Pyper</td>
</tr>
</tbody>
</table>

This revised bulletin describes, for clinical coders in WA public hospitals, the 5 coding standards specific to WA. Particular attention is drawn to revised instructions in two areas:

- admission for post-operative care and
- coding of spontaneous vaginal delivery.

Dr Neale Fong

DIRECTOR GENERAL

DEPARTMENT OF HEALTH
TITLE : WA CODING STANDARDS
DISTRIBUTION: ALL PUBLIC HOSPITALS IN WESTERN AUSTRALIA

1. Purpose
The purpose of this bulletin is to outline coding standards specific to Western
Australia.

2. Background
Since the introduction of the first Australian Version of ICD-9-CM in 1995, clinical
coders in WA have been instructed, by the Department of Health, to follow the
Australian Coding Standards (ACS), in line with the terms of the Australian Health
Care Agreements.

Exceptions to this general rule are based on:
- Policy
  Policy outlined in specific Technical Bulletins has implications for clinical
coding in WA. For example, instructions for the recording of cancelled
procedures are based on Admission Policy for WA Hospitals (Technical
Bulletin 17/3).
- Audit findings
  Clinical Information Audits, conducted by the Department of Health between
1997 and the present date have indicated specific areas of contention,
ambiguity and non-compliance.

To address these issues, Coding Standards specific to WA have been drafted by the
Department of Health and submitted to the Coding Committee of WA for approval
and ratification. Five WA Coding Standards have been ratified by that Committee at
various meetings between 1998 and the present date. These coding standards,
specific to WA, pertain to:
- cancelled elective procedures
- psychiatric diagnosis with self-injury/overdose
- spontaneous vaginal delivery
- place of occurrence and activity codes and
- drug toxicity.
The WA Coding Standards are designed to resolve ambiguities in existing instructions and promote uniformity of practice. They primarily enlarge upon and clarify existing rules. Compliance will continue to be monitored in future audits.

All other coding decisions follow the Australian Coding Standards (ACS), 5th Edition, 1 July 2006 and the quarterly publication of the National Centre for Classification in Health (Coding Matters). Unless specifically advised otherwise, instructions from ‘Coding Matters’ are effective immediately. All other major changes in practice (for example the introduction of new codes) should be followed from the 1 July following publication of a new instruction. If in doubt please contact the Information Collection and Management Unit, Department of Health (tel 9222 2472)

In addition to the WA Coding Standards, this bulletin includes a description of educational requirements for clinical coders (Appendix 3).

3. Deleted Standards
Refinements to DRG grouping logic and reporting practices have rendered obsolete, two previous WA standards:

WACS 01 - Admission for aftercare/convalescence
WACS 03 - Irritable Baby

Superseded By:
OD 0154/08
Appendix 1 - WA Coding Standards (WACS)

WACS 01 - Deleted

WACS 02 - Cancelled Procedures

1. Same Day Stay
If an admission is reported for:
   - a booked elective procedure which is then cancelled,
   the principal diagnosis assigned is a code from Z53.x.

These admissions will be excluded from the file for calculations of admissions to hospital as they do not meet admission criteria. They should be recorded as non-admitted occasions of service (see Technical Bulletin 19/3).

This excludes same day stays which are classifiable as continuing admissions (2).

2. Continuing Acute Admissions
If a patient presents to hospital for a booked elective procedure which is cancelled, but the admission continues for acute inpatient management of some other condition or symptom, that condition/symptom is assigned as principal diagnosis.

The condition for which the procedure was originally planned is not coded, unless it meets the criteria for the coding of additional diagnoses-ACS 0002. For example, if a scheduled hip replacement is cancelled due to chest infection, but admission continues for inpatient management of chest infection, the principal diagnosis assigned is J22 (chest infection). Osteoarthritis of hip may be added subject to ACS 0002. Z530 is added as an additional diagnosis. Continuing admissions will usually be overnight but can be same day.

3. Overnight Stay to Await Scheduled Surgery
When a patient is admitted the day prior to a scheduled procedure (due to age or distance from hospital) and the procedure is subsequently cancelled, the episode should be reported as non-acute (maintenance) care. The principal diagnosis assigned is “other waiting period for investigation and treatment” (Z75.2).

Additional codes will be Z53x plus any conditions meeting the additional diagnosis criteria (ACS 0002).

This excludes any cases classifiable as continuing acute admissions (2).

A flow chart to assist clinical coders is appended (Appendix 2).
WACS 04 - Psychiatric Diagnosis with Overdose or Injury
The sequencing of the principal diagnosis for patients who are admitted to hospital with a minor overdose or injury due to self harm and whose stay in hospital is comparatively long causes problems for coders.

Often a superficial injury would not require an admission to hospital and the primary focus of treatment, where admission does occur, is the underlying psychiatric condition.

ACS 0530 states that where a patient is admitted for treatment of a drug overdose, and the patient subsequently receives treatment for an associated psychiatric condition in the same episode of care, the overdose should be sequenced as the principal diagnosis. This direction may not apply in WA when it is clear that the principal reason for the admission was to treat, for example, depression or an anxiety state. Coders should follow the normal rules for assignment of principal diagnosis (ACS 0001).

WACS 05 Spontaneous Vaginal Delivery
The assignment of a code for spontaneous vaginal delivery (90467-00) is mandatory in WA. The uniform reporting of this code facilitates research requests for mode of delivery in WA.

In obstetric cases, the principal diagnosis is the condition most relating to the mode of delivery. Accordingly, the principal procedure for all delivery episodes should be the mode of delivery (Caesarean, forceps, vacuum, breech or SVD).

In multiple births, a code for mode of delivery is assigned for each newborn delivered (excluding multiple births, all by Caesarean section).

Example 1:
Principal Diagnosis: O80 Single spontaneous delivery
Additional Diagnosis: Z37.0 Single liveborn infant
Principal Procedure: 90467-00 Spontaneous vaginal delivery
Additional Procedure: 90472-00 Episiotomy

Example 2:
Principal Diagnosis: O64.3 Obstructed labour due to brow presentation
Additional Diagnoses: O32.5 Multiple gestation w malpresentation
O30.0 Twin pregnancy
Z37.2 Twins both liveborn

Principal Procedure: 90468-01 Forceps delivery Twin 2
Additional Procedure: 90467-00 Spontaneous vaginal delivery Twin 1

(note: if both twins are delivered by SVD, the code is repeated, 90467-00, 90467-00)
WACS 05 – Spontaneous Vaginal Delivery (cont/d)

Termination of Pregnancy (TOP): An SVD code (90467-00) is never assigned for any termination of pregnancy, (at any gestational age). TOP coding, particularly for late terminations, is subject to highly specific rules (ACS 1511, 1510) which vary significantly from normal obstetric coding practices.

WACS 06 Place of Occurrence and Activity Codes
External cause codes record how an injury occurred or add additional information about diagnoses or effects of treatment. ACS 2001 instructs coders that if there is an external cause of a condition, a code from V01-Y89 is required to add additional information to diagnostic and procedural codes. Coders are instructed to contact their state health authority regarding special circumstances (see ACS 2001, page 265). In WA, external cause, activity and place of occurrence codes are always mandatory with diagnostic codes S00-T99 and with codes outside that range where appropriate.

The Australian Coding Standards instruct that activity codes are not required for some external cause codes. However in WA a ‘Place of Occurrence Code’ (Y92.0 – Y92.9) and an ‘Activity Code’ (U50 –U73) are required for all external cause codes (V01-Y89), to comply with computer system requirements in both public and private hospitals.

The place of occurrence and the activity may not be known. In such cases Y92.9 and U73.9 are the default codes.

This instruction overrules the note in ICD 10, Tabular List, page 463. In WA, activity and place of occurrence codes are required whenever an external cause code has been used.

WACS 07 Drug Toxicity
NB This standard addresses drug toxicities in therapeutic use. Toxicity in recreational use of drugs, drug abuse, and suicide/parasuicide follows the normal coding rules (ACS 1901).

Therapeutic (iatrogenic) poisoning is a particular research interest of the University of WA- School of Public Health. Many such poisonings are associated with accidental overdose, prescription error and drug interactions. These scenarios are adequately dealt with under existing Australian Coding Standards (1901, 1903).
WACS 07 Drug Toxicity (cont/d)

Other therapeutic poisonings may occur when, through accumulation, drugs reach toxic levels outside of the normal therapeutic range. There may be no documented improper use by the patient nor any documentation of prescription error or dosage error on the part of clinical staff.

When the terms “toxicity” or “intoxication” are used to describe therapeutic poisoning, without any documentation of improper use or medical misadventure, assign a code for poisoning (T36 – T50) with an external cause code from Y40 – Y59.

Where toxicity or intoxication is used in a more general sense, to describe the side-effects of a drug, without evidence of toxic levels, assign a code for the specific side-effect (see ACS 1902).

Where the coder is uncertain as to the correct interpretation the clinician should be consulted. As a default position, code a diagnosis of toxicity as per the Alphabetic Index, page 405: “toxicity- from drug – see Table of drugs and chemicals” (T36 –50). Where no improper use or medical misadventure is evident, the default external cause range is Y40-59.
Appendix 2 Cancelled Procedures Flowchart

ACS – Australian Coding Standard  WACS- WA Coding Standard

Emergency Admission

Yes

See ACS 0011

No

Patient already in theatre or procedural unit?
Patient already received oral or IV pre-med?
Anaesthetic administered (including LA)?
Infusion / dialysis / transfusion commenced?
See ’Additional Notes 1’

Yes to any of these criteria

See ACS 0011

No to all of the above

Despite the cancellation, was there inpatient investigation or treatment of any condition or symptom under doctor’s orders?
See ’Additional Notes 2’

Yes

Code that condition or symptom as the Principal Diagnosis (WACS 02)

No

Patient discharged same day?

Yes

Code Z53.x as Principal Diagnosis
No other codes required
See WACS 02
See ’Additional Notes 3’

No

Multi-day stay

Yes

Code Z75.2 as Principal Diagnosis
Also code Z53.x and other diagnoses that meet ACS 0002
Alter ‘Care Type’ to Maintenance
See WACS 02
See ’Additional Notes 4’
Additional Notes

1) In ‘theatre’ or ‘Procedural Unit’ includes –
   - Endoscopy suite
   - Cardiac catheter laboratory
   - Radiology (eg where procedure performed under CT guidance)

2) Treatment or investigation of any specific condition or symptom under doctor’s orders includes –
   - Procedure initially postponed while patient has investigations (CT or Nuclear Medicine scan) for a worrying symptom, resulting ultimately in cancellation
   - Patient may stay after cancellation for medical treatment of original condition or treatment of a contraindication
   - Patient may stay for treatment or investigation of some other condition or symptom, not necessarily defined as a contraindication

3) No other diagnostic or procedural codes required. However, additional codes can be used for a hospital’s internal purposes, if necessary. These cases will be removed from the Hospital Morbidity Data System (HMDS). Public hospitals should count these cases as outpatient occasions of service.

4) Code also Z53.x and any other codes which meet normal coding rules (i.e. ACS 0002) and other mandatory codes, like Z72.0. Acute care cases will have been removed as per Note 2. However, some cases have additional monitoring for diabetes, dementia or other chronic conditions and these should be coded as additional diagnoses. None of the Z75.2 cases will be removed from the HMDS.
Appendix 3   Education and Training of Clinical Coders

Consistency and accuracy in coded morbidity data is largely dependent upon the skills and training of the clinical coder. It is strongly recommended that coders have completed formal education in a nationally recognised course. In addition, new coders should undergo an initial period of validation of their work by the Information Collection and Management Unit (ICAM), Dept of Health.

Recommendations for Health Services/Hospitals

- Ensure that clinical coders have completed a recognised clinical coding course prior to employment.

- Notify the State Coding Educator of any new coder appointed (including contract and casual coders). Data coded by new coders will be monitored initially and feedback will be provided.

- Encourage liaison between coder and ICAM regarding coding queries, data edits and ongoing education.