From: Nicolle Predl
To: submissions ihpa
Cc: DOWNIE, James; FITZGERALD, Joanne; Brian Hanning
Subject: Public consultation – AR-DRGv10.0 [SEC=No Protective Marking]
Date: Wednesday, 6 June 2018 12:52:28

Dear James

Thank you for the opportunity to comment on the AR-DRG v10 classification. In response to the specific questions raised, AHSA has the following feedback:

Diagnoses excluded from complexity calculation

1. ***Are there diagnoses proposed for exclusion (refer to Appendix B) that are considered significant in contributing to the complexity of treating a patient in an admitted episode of care that should remain in the complexity calculation for AR-DRG V10.0?***
   Not to our knowledge.

2. ***Are there other diagnoses not proposed for exclusion that should be added to the exclusion list?***
   Not to our knowledge.
   Note that tightening of ACS002 would provide greater controls of any over use of certain complex conditions, such as constipation, irrespective of the DRG version being used, rather than fixing on a version to version basis.

Stability of complexity calculations between AR-DRG versions

3. ***Do you support the introduction of stabilisation methods to the AR DRG complexity model?***
   Yes

4. ***Are there other areas of the complexity model IHPA should be investigating to ensure stability between AR-DRG versions?***
   Not to our knowledge.

Caesarean Sections

5. ***Do you support the proposal to differentiate caesarean section types in the AR-DRG classification?***
   Yes – providing that a proper risk assessment has been made that ensures this practice is not open to gaming.

6. ***Do you support using in labour or not in labour as the measure for differentiating caesarean sections in the AR-DRG classification?***
   Yes, providing that the diagnoses originally proposed at the DTG are reviewed to ensure that they are relevant.

Nephrolithiasis interventions

7. ***Do you support the proposed grouping of nephrolithiasis interventions in the AR-DRG classification for V10.0?***
   AHSA would like further information to support that there is minimal cost variation between different interventions for nephrolithiasis. AHSA questions whether the cost of capital such as lithotripters could be compared to other interventions within the same ADRG.

We are pleased that open procedures would move to surgical ADRGs.

Removal of DRG for rehabilitation

8. ***Do you support the removal of Z60 Rehabilitation on the basis that this ADRG is obsolete as a result of changes to the ACS?***
   Yes.

Liver procurement from a living donor

9. ***Do you support reassigning living donor liver procurement episodes to ADRG H01 Pancreas, Liver and Shunt Procedures?***
   Yes.

Osseo-integration interventions

10. ***Do you support reassigning episodes with osseo-integration interventions of the digits and limbs to ADRG I28 Other Musculoskeletal Procedures?***
    Yes.

Consideration of interventions not currently accounted for in the AR-DRG classification

11. ***Do you agree with the recommendations that no change be made for AR-DRG V10.0 for acute rheumatic fever, personality disorders, involuntary mental health patient episodes, alcohol and drug disorders, dental extractions and restorations, endovascular clot retrieval, trans-catheter aortic valve implantation, repetitive transcranial magnetic stimulation and stereo electroencephalography?***
    Yes.

Other

12. ***Do you foresee any system issues with the increase in characters of the AR-DRG version number with the introduction of AR-DRG V10.0?***
    Yes.
    Some health funds have indicated that their systems are not currently able to handle the expansion from a 2 character to 3 character field. This is also important in the context of recent DTG discussions which proposed that incremental versions will be considered in future development (eg 10.1, 10.2 etc).
    Furthermore, the private sector, which do not operate in DRG mandate environment in terms of reporting and funding, have the DRG Version as a reportable field in several datasets, including:
    - Hospital Casemix Protocol (HCP)
    - Private Hospitals Data Bureau (PHDB)
    - (Electronic Claim Lodgement and Information Processing Service (ECLIPSE)

    These datasets will require structural changes, at a significant cost to industry, to expand the field size from 2 to 3 characters. This will affect some fund systems, and the impact to other downstream systems both public and private is unknown.

Should you require any further information, please do not hesitate to contact me.

Kind regards
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