8 June 2018

IHPA

Re: Consultation on AR-DRG v10.0

2.1 Refinement of clinical complexity level

The comment is noted that the focus of the review of the in-scope codes included "…codes with a high rate of increase in assignment that appears to coincide with the introduction of pricing using AR-DRG V8.0 on 1 July 2016". Data captured since 1 July 2016 should reflect a more complete view of the episode of care as the majority of diagnosis codes have a complexity value so technically all become important to describing the episode. Of course, in practice, demands on coders will still mean that not all conditions are clarified with clinicians to enable them to be coded. However, the data may be more correct than previously collected data where there was a limited number of codes with complexity values that coders clarified. So to consider codes with a high rate of increase in assignment for exclusion ignores that some other codes may have been assigned frequently in the past and be of no more value to the episode than the code that has now been chosen to be excluded. For example, abnormal magnesium (a code given a complexity value from v8) vs abnormal potassium (a code that has had a complexity value for many years).

I am aware of the 'overcoding' that has contributed to the increase in code assignment but this has occurred due to the lack of specificity and loose interpretation of ACS 0002 *Additional diagnoses*. This ACS needs to be modified to ensure the coded data is fit for purpose and I am aware that ACCD is working on that.

There is also concern about the review of codes for exclusion that are "…not clinically significant in contributing to episode complexity". I believe it is very hard to determine that a condition is not clinically significant to all episodes of care, and if codes are accurately assigned, then the coded data and its associated costing data, should determine the inclusions and exclusions in the grouper.

Constipation (K59.0) is a good example of a code with a large increase in assignment since 2016; in many episodes it is not clinically significant (but queried and coded because ACS 0002 appears to allow it to be assigned) but can be clinically significant in terms of treatment required (e.g. multiple different medications including enemas ordered by the doctor over a number of days).

Cancer in remission codes are listed for exclusion but ACS 0245 *Remission in malignant immunoproliferative diseases and leukaemia* states that 'in remission' may be assigned when the patient is still receiving treatment for the inactive malignancy; if the patient is

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receiving chemotherapy during the episode, the condition should be considered as having a complexity to the episode.

Many codes could be the reason for surgery in the episode but are listed for exclusion, e.g. goitre, leiomyoma of uterus, dental anomalies, hernias; the condition should be considered as having a complexity to the episode.

Review of "…codes that may be considered ill-defined" may lead to a large increase in the need for coders to clarify diagnoses with clinicians, adding to the workload in an area that is already under staffed in many health services. For example, low back pain (M54.5) is a common diagnosis as the reason for admission (particularly in pain management episodes); it probably has a cause but it is not documented; to gain a complexity level, the coder would need to clarify this diagnosis with the clinician.

I note a range of obstetric codes are listed for exclusion but I am unsure which category these codes fall into – they are not ill-defined codes, would not expect to had a high rate of increase of assignment and should not be considered as not clinically significant. In a delivery episode, these are the codes that must be assigned and another code may be assigned if there is further specificity – both codes should not receive a complexity level, but the code that must be assigned, should be the code with the value.

2.2 Caesarean sections

Yes, I support the split between emergency and elective caesarean section DRGs but have concern that some patients who are not in labour require an emergency caesarean section so would not be able to group to the emergency caesarean section DRG.

I agree with or have no further specific comments on the other consultation questions.

Regards,

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