Feedback - consultation paper on
Australian Refined Diagnosis Related Groups Version 10.0

Name of Unit, branch, Division or HHS

Dated: XX May 2018

Consultation question	Feedback
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?	As a large majority of these codes fit within the "unspecified" category, the exclusions are in keeping with ACS and the directive for coders to always either seek clarification or further specificity from clinicians, with the expected outcome of a code where the condition is specified and therefore attract complexity score. Clinician review of the exclusion list for clinical significance should be a driving factor, not a focus on whether a code has a high rate of increase in assignment. Some of these conditions from a data review perspective may appear seemingly minor in the clinical scheme of things, but they do have the potential to be increasing LOS, increasing observation intervals and nursing cares given which is impacting on the costs associated with caring for the patient.
2. Are there other diagnoses not proposed for exclusion that should be added to the exclusion list?	No
3. Do you support the introduction of stabilisation methods to the AR DRG complexity model?	Agree that evaluation and stabilising is important and at each version. As these measures are still under development and testing it is difficult to agree to the measures rather than just support the concept.
4. Are there other areas of the complexity model IHPA should be investigating to ensure stability between AR-DRG versions?	Review of the steady increase in the number of DRGs over the past 3 AR-DRG versions. More DRGs doesn't necessarily translate to a more stable classification.
5. Do you support the proposal to differentiate caesarean section types in the AR-DRG classification?	Yes, the costing differential between an elective caesarean section and emergency caesarean section can be quite vast and whilst it is acknowledged that a high proportion of emergency patients do fall in to the higher A DRG category, there were still 30% that fell within the lower weighted O01C DRG.
6. Do you support using in labour or not in labour as the measure for differentiating caesarean sections in the AR-DRG classification?	Differentiating based on in labour or not in labour makes sense from a clinical sense and a resourcing perspective of time spent in labour ward and interventions used up until the point of decision to go to caesarean section. Could this perhaps be captured via ACHI code with a split at the 6/7 character level?
7. Do you support the proposed grouping of nephrolithiasis interventions in the AR-DRG classification for V10.0?	Yes as long as complexity splits are assessed and refined to ensure optimum resource homogeneity at a DRG level.

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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 as it is no longer used due to ACS changes. However it would be useful to have DRGs that are mappable to the SNAP codes based on the PDx of an episode that is Non-acute and contains Z50.9 in the code string. For example a DRG for each Rehabilitation class - Neuro conditions, Stroke, Ortho-fracture, Ortho-replacement, Reconditioning etc.
9. Do you support reassigning living donor liver procurement episodes to ADRG H01 Pancreas, Liver and Shunt Procedures?	Yes, makes classification more consistent
10. Do you support reassigning episodes with osseointegration interventions of the digits and limbs to ADRG I28 Other Musculoskeletal Procedures?	Yes
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, transcatheter aortic valve implantation, repetitive transcranial magnetic stimulation and stereo electroencephalography?	The rationale for making no changes is understood however this highlights that work needs to be done in ACHI as a priority so that the flow on DRG changes can be achieved. In particular in the area of stereo electroencephalography as the current classification and DRG allocation does not adequately capture the complexity of these highly specialised patients. A submission for changes to the DRG was sent to ACCD in November 16.
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?	This item has been referred to our systems support for review of our internal capabilities as well as confirming with our systems vendors that they will be able to adapt to the increase in characters