Public consultation open – Australian Refined Diagnosis Related Groups classification Version 10.

Tasmanian response

1. Are there diagnoses proposed for exclusion (refer to <u>Appendix B</u>) 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?

Some of the removed codes are significant in some circumstances – for example constipation may not be such an issue for most patient cases particularly if not requiring aggressive management, and we do not support the codling of constipation for prophylaxis. However we do support that coding and grouper consideration of constipation is maintained in other cases particularly where management of another condition is considerably impacted by the constipation – such as stroke, intracranial aneurysms, following cardiac surgery, abdominal surgery, diverticulosis, uterine/rectal prolapse and so on. A consequence of laxative overuse should also be coded.

Global suppression of constipation as a grouping variable in reflecting additional severity is not appropriate in all cases.

2. Are there other diagnoses not proposed for exclusion that should be added to the exclusion list?

The initial examination of unspecified (as distinct from unspecifiable) ICD codes is useful; this should be undertaken at each major revision. Consideration should be given to those conditions where "unspecified" is inappropriate regardless of the circumstances of the hospital admissions – e.g. unspecified Pressure injury. There are some cases however, there unspecified may be appropriate, such as the diagnosis is not immediately available.

Tasmania believes the initial list is a good beginning for this.

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

The complexity model should be under constant study. The statistical process is the model can and should be also subject to clinical review involving *specialist* input from *relevant* clinician groups – i.e. if considering a neurological condition then reference to the neurologists should be required.

4. Are there other areas of the complexity model IHPA should be investigating to ensure stability between AR-DRG versions?

The gaming of Coding is an ongoing issue. The current approach of modifying both the grouper response to codes and the suppression of coding for chronic conditions may be overkill and will reduce the value of coded information for safe and appropriate patient management. We do not agree with some of the proposed changes to the coding standard. Our view is that coding should reflect;

*   The conditions that impacted the care a patient receives during an episode in terms of clinical care, investigation and monitoring that is additional from normal management that a patient would receive than if they did not have the condition.
*   the events and conditions that occurred during the episode including complications and where these conditions impact on the management of other conditions that the patient has or where

other conditions that the patient has impact on management of the condition; i.e. where a condition complicates or is complicated by another condition

- The interventions that were performed on the patient.

5. Do you support the proposal to differentiate caesarean section types in the AR-DRG classification?

Yes

6. Do you support using in labour or not in labour as the measure for differentiating caesarean sections in the AR-DRG classification?

Yes

7. Do you support the proposed grouping of nephrolithiasis interventions in the AR-DRG classification for V10.0?

Yes

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?

No issue in Australia

This may cause some problems for international users of the Classification.

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

Yes

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?

Yes

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?

No comment