Tuesday, June 15, 2021

The Secretariat
Independent Hospital Pricing Authority
Submissions.ihpa@ihpa.ihpa.gov.au
PO Box 483
Darlinghurst NSW 1300

Dear IHPA Secretariat,

Re: Development of the admitted care classifications – Public Consultation Submission from Austin Health

Thank you for the opportunity to provide comments on the Development of the admitted care classification. Please find attached our submission.

Sincerely,

Kemsley Fairhurst
Chief Financial Officer

Submission from Austin Health

Prepared by Health Information Services, Performance Reporting and Decision Support
Key Contact: Kate Wendt, Operations Manager, Health Information Services and Coding

(3.1.3) 1. Are there any additional requirements in coded activity data regarding the classification of COVID-19 that should be prioritised for Twelfth Edition?
Not additional, but if U06.0 is going to be replaced by a generic Z03.x code then it's important to have an ACHI code for COVID-19 testing otherwise these scenarios would be lost among other observation scenarios. An ACS specific to COVID coding requirements would also be of great benefit

(3.1.4) 2. Is there support to align the coding practice of sepsis with the Sepsis-3 definition?
Yes

(3.2.4) 3. Most interventions in the admitted care setting are able to be classified to a code even though sometimes the code might not be specific. Are there other new interventions that should be uniquely classifiable in ACHI?
Thermocoagulation of tissue, currently Thermocoagulation codes as neurotomy, however currently there is a procedure involving thermocoagulation of cortical tissue. Clinical staff believe the current coding pathway does not accurately reflect the procedure.

(3.2.4) 4. Are there other concepts or additional terminology that should be incorporated for engineered cell and gene therapies to ensure that current and emerging new health technology can be accurately classified?
No further comment from Austin Health

(3.2.6) 5. What are common terms used in clinical documentation to identify the consultation liaison psychiatry (CLP) service? and
Consultation Liaison Psychiatry is standard term/ definition present in our clinical documentation to identify when a patient has received care from the CLP Service. Further Clinical Health and Psychology (CHP) is also clearly defined in our clinical documentation, where psychology staff provide services to patient. Within Austin Health these are 2 clearly defined services. The same procedure code would be used to capture services provided by both CLP and CHP.

6. Is there a standard definition used to describe consultation liaison psychiatry (CLP) services?
The CLP definition used at Austin Health is:
"the sub-specialty discipline of consultation-liaison psychiatry, and involves the assessment and management of a broad range of psychiatric and psychological conditions and psychosocial issues in collaboration with other health professionals, often in the hospital setting, and with particular attention to the interaction between psychiatric illness and medical systems."

Clinical and Health Psychology Services (CHP) works closely with the Consultation Liaison Psychiatry Service. CHP is described as providing: Clinical and health psychologists across Clinics are able to provide expert treatment for a broad range of health-related and other psychological disorders.

(3.3.1) 7. What is the most significant part of ACS 0002 Additional diagnoses, requiring clarification to promote consistency of application without changing the intent of the standard?
Greater clarification is needed regarding Increased Clinical Care which includes:
• *receiving clinical consultation for a condition with documentation of:*
•*a clinical assessment, and*
•*a diagnosis, and*

•*a care plan for the condition (eg patient referral to an oncologist for cancer assessment with documentation of advice received; wound specialist/nurse assessment of pressure injury with documentation of staging of pressure injury and care plan).*

Note that a care plan may include an adjustment to, or continuation of, the current treatment plan, or transfer to another facility with documentation of the reason(s) for transfer (see Examples 12, 21 & 22)

Specifically, it would be good to have greater guidance with examples for:

1. Does a plan of care that is clearly documented but not carried out within the admission (eg a plan to wean medication after discharge / for tests to be done at a later date) meet this criteria? VICC 3646 addresses this but obviously that is Vic only
2. If a patient is admitted with a known condition and pre-existing treatment plan (eg transferred from another facility or from acute to sub-acute on medication for hypotension) and there is a simple note by a clinician of 'Hypotension - continue xx medication' with no further assessments documented and no change to the medication- does this meet criteria?
3. If there is a clinical assessment performed but the plan of care is that no action is required, does this meet criteria?

(3.4) 8. Do you have any additional feedback on the proposed changes for ICD-10-AM/ACHI/ACS Twelfth Edition?

- Re 3.3.3 'The update to ACS 0044 for Twelfth Edition will also include updated classification advice on the use of prophylactic pharmacotherapy that will be distinguished from regular pharmacotherapy for neoplasms.' - this is good. It should incorporate advice in ACE 'Clarification of ACS 0236 Neoplasm coding and sequencing' and ACCD 'Same-day admissions for chemotherapy/pharmacotherapy for neoplasm(s) and neoplasm related conditions'
- ACS 1008 *CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)* is proposed for deletion because apparently it is already covered by the Indices (3.3.4). We do not agree that the Indices are clear enough in relation to 'From a classification point of view, the presence of COPD with pneumonia is sufficient to assign J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection.' This should be further clarified prior to the deletion of ACS 1008
- ACS 1807 *ACUTE AND CHRONIC PAIN* it would be beneficial to retain example 4 elsewhere in the ACS
- Plus requests for further changes:
    - NCCH 'Pain versus injury post trauma' should be made into an ACS as this advice is really very old now.
    - Could ACS 1904 *Procedural Complications* be revised to confirm whether the term "complicated by" infers a causal relationship? VICC 3551 says no it does not but obviously that's VIC only advice. But we see this documented fairly frequently.

(4.1) 9. Do you agree with the diagnoses that are proposed for exclusion in AR-DRG V11.0 based on the guiding principles for exclusion? If not please provide evidence that may lead to the recommendation for exclusion being reconsidered (see Table 2).
Yes. No further comment from Austin Health

10. Are there other diagnoses not proposed for exclusion that should be added to the exclusion list?
No comment from Austin Health

11. Do you support the proposed ICD-10-AM code categories for DCL precision in AR-DRG V11.0?

12. Do you support the proposed cost groups within the ICD-10-AM code categories (see Appendix C) for DCL precision in AR-DRG V11.0?
Yes. No further comment from Austin Health

(4.1.2) 13. Do you support the proposed ADRGs for the General Interventions (GIs) and principal diagnoses outlined in Appendix B.1 and B.2 on the IHPA website?
Yes. No further comment from Austin Health

(4.1.3) 14. Do you support the proposal to create an ADRG specifically for endovascular clot retrieval (ECR) in AR-DRG V11.0?
Yes. No further comment from Austin Health as this would align with the current VIC DRG

(4.1.4) 15. Do you support the proposal to reassign percutaneous cardiac valve replacement (PCVR) interventions in ADRGs F03 Cardiac Valve Interventions W CPB Pump W Invasive Cardiac Investigation and F04 Cardiac Valve Interventions W CPB Pump W/O Invasive Cardiac Investigation to F19 Trans-Vascular Percutaneous Cardiac Interventions?

16. Do you support the proposal to remove PCVR interventions from ADRG F05 Coronary Bypass W Invasive Cardiac Investigation and F06 Coronary Bypass W/O Cardiac Investigation?
Yes. No further comment from Austin Health

(4.1.5) 17. Do you support the proposal to create a specific ADRG for peritonectomy?
Yes. No further comment from Austin Health

18. Is there support for the removal of the sex conflict test in AR-DRG V11.0 and instead rely on the selection of principal diagnosis to drive grouping for episodes in MDC 12 Diseases and Disorders of the Male Reproductive System, 13 Diseases and Disorders of the Female Reproductive System and 14 Pregnancy, Childbirth and the Puerperium?
Yes. No further comment from Austin Health

19. Do you have any additional feedback on the proposed changes for AR-DRG V11.0?
No further comment from Austin Health