

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
By email: submissions.ihpa@ihpa.gov.au



Dear Mr Downie,

Re: Australian Refined Diagnostic Related Groups (AR-DRG) classification Version 10.0

Thank you for the opportunity to provide feedback on the stakeholder consultation paper for the Australian Refined Diagnostic Related Groups (AR-DRG) classification V10.0. As you know, Children's Healthcare Australasia's (CHA) membership comprises both specialist children's hospitals and general hospitals providing paediatric services, large and small. We have consulted our members about the questions posed in the consultation paper for AR-DRG V10.0. This submission offers feedback related only to children's health services.

CHA supports IHPA's ongoing efforts to develop the AR-DRG classification to ensure that it remains a contemporary classification system that reflects current clinical terminology and clinical practice whilst enabling coherent grouping of admitted episodes for costing purposes.

IHPA is seeking written comments on the following questions:

- 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?**

CHA members have reviewed episodes for the 2016/17 period. This review demonstrated that whilst codes identified in Appendix B appear to be low complexity, analysis of average costs indicate that those which include one or more codes from Appendix B are associated with higher costs and therefore higher complexity. CHA therefore suggests that broader analysis should occur prior to removal of these codes from the complexity model for children.

CHA members have identified a number of specific diagnoses that are considered significant in contributing to the complexity of treating a paediatric patient. These include:

- All leukaemia in remission codes as this is coded early on during treatment and it is an important complicating factor. Patient's usual pattern is to go 'into remission' on bone marrow aspiration reports a few weeks/months into treatment and as soon as this occurs patients are coded to 'leukaemia in remission'. When patients are admitted with complications after

treatment starts the leukaemia is an important diagnosis in the complexity of each admission, as it is still current and under treatment, even though it is coded to 'in remission'.

- E16.2 Hypoglycaemia
- E83.3 Disorders of phosphorus metabolism
- E83.4 Disorders of magnesium metabolism
- K55.9 Vascular disorders of intestine – ischaemia of intestine can be a serious complication during an admission
- K59.0 Constipation – this can be serious in the paediatric population and require intense investigation and intervention
- N18.3 CKD stage 3 and N18.9 Unspecified kidney failure – not always specified in paediatrics
- P39.9 Infection specific to the perinatal period, unspecified
- P92.0 Vomiting in newborn
- R65.0 SIRS of infectious origin without acute organ failure

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

At this time CHA has not identified any further diagnoses for addition to the exclusion list.

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

A subset of CHA's member's in Victoria have experience with the WIES model which limits cost weight changes between years so that funding arrangements remain fairly predictable. Based on this experience CHA supports the introduction of stabilisation methods to the AR-DRG complexity model.

The consultation paper discusses the three main areas where volatility can be monitored, overall complexity shifts, diagnosis level complexity and splits within the AR-DRG in general terms only. CHA notes that IHPA intends to develop and test these stability measures in consultation with IHPA's advisory groups. CHA members are keen to understand how these areas will be monitored and adjusted to stabilise changes.

CHA suggests that IHPA should undertake further consultation regarding the proposed methods for stabilisation with the health industry prior to implementation.

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

CHA supports the use of stability measures for continuous refinement of the AR-DRG based on the most recent cost and diagnosis data whilst providing for classification stability year on year. CHA and its members are satisfied that the stability measures identified in *Table 1: Potential AR-DRG*

complexity stability measures as; overall stability performance measure; stability of Diagnosis Complexity Level values and stability of complexity splits within ADRGs will provide sufficient levers to maintain stability year on year.

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

Nephrolithiasis intervention codes are not commonly used in paediatric hospitals. CHA therefore supports the grouping of nephrolithiasis interventions in the AR-DRG classification for V10.0.

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

CHA supports the removal of the Z60 *Rehabilitation* and agree that the code is obsolete and we can confirm that it has not been coded by CHA members in recent years.

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

CHA supports reassigning the living donor liver procurement episodes to ADRG H01 *Pancreas, Liver and Shunt Procedures*. CHA notes that this reassignment brings the procedure in line with live kidney donors. CHA acknowledge the importance of ensuring the AR-DRG classification maintains consistent logic across codes and are supportive with ongoing efforts to this effect.

8. Do you support reassigning episodes with osseointegration interventions of the digits and limbs to ADRG I28 *Other Musculoskeletal Procedures*?

CHA supports the regrouping of episodes from I15 to I28 *Other Musculoskeletal Procedures*. CHA notes that paediatric hospitals carry out very few of these types of procedures.

9. 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?

CHA agrees that no change is required for acute rheumatic fever, personality disorders, involuntary mental health patient episodes, alcohol and drug disorders, dental extractions and restorations, endovascular clot retrieval and transcatheter aortic valve implantation. However CHA suggests the

addition of more specific codes for repetitive transcranial magnetic stimulation and stereo electroencephalography to better reflect this procedure.

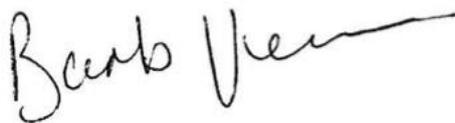
10. Do you foresee any system issues with the increase in characters of the AR-DRG version number with the introduction of AR-DRG V10.0?

CHA members do not forecast any specific system issues related to an increase in characters of the AR-DRG version. CHA members acknowledge that systems will inevitably need to accommodate the change and adjusting field length should be all that is required.

Further information.

CHA would be happy to facilitate further discussion with members about these matters if you require clarification or further explanation for any of the comments provided here. Please don't hesitate to contact me if we can assist further. Thank you again for the opportunity to provide advice on these matters.

Kind regards



Dr Barbara Vernon
Chief Executive Officer
Children's Healthcare Australasia

8 June 2018