Submissions should be emailed to IHPA Secretariat at **submissions.ihpa@ihpa.gov.au**.

3.2 ACHI updates for Twelfth Edition

We've had data requests for patients who've had Child Protection Unit assessment and intervention and currently there is no code available to identify these patient cohorts. The prevalence of domestic violence and child safety are higher today, a specific ACHI code would be useful to hospital reporting and research. If we were to search on a procedure code for example it would be a lot easier than searching based on various documented reasons for child protection unit involvement.

3.3.4 Standardisation of structure and format of the ACS

The first stage of the review identified ACS for potential deletion by incorporating content within the ICD-10-AM and ACHI Tabular Lists and Alphabetic Indices. For example, ACS 2118 Exposure to tobacco smoke contains no additional classification instructions for clinical coders and the classification rubrics such as the excludes notes under the code Z58.7 Exposure to tobacco smoke already direct coders appropriately. Therefore, this ACS is proposed for deletion.

Feedback:

ACS 2218 Classification provides direction for coders to *assign Z58.7 when exposure to second-hand tobacco smoke is documented by a clinician,* therefore this standard indicates Z58.7 can be assigned even when it does not meet ACS 0002. If ACS 2218 is deleted, coders would have to apply ACS 0002 for this status to be coded, as there is no longer direction for it to be always coded when documented. Is this IHPA's intention? If so then that will work, otherwise a classification note will be required in ACS 0503 under **Tobacco use disorder** to always code exposure to second-hand tobacco smoke when documented by a clinician.

There are a lot of very good ACS for deletion and I would like to please see that they get incorporated into the index or Tabular notes before deletion occurs.

4.1.1 Complexity Model Revision

ICD-10-AM code	Code description	Rationale for exclusion
K56.7	*Ileus, unspecified*	Anecdotally it appears that this code may be assigned postoperatively when it is an indication for the insertion of a nasogastric tube. In such circumstances it is generally considered a minor and expected outcome of surgery, particularly gastrointestinal surgery. Analysis using three years of acute prepared data from 2016–17 to 2018–19 demonstrates that when assigned as an additional diagnosis 96 per cent group to ADRGs within the intervention partition, with the highest percentage in ADRG G02 *Major Small and Large Bowel Interventions*.

I've seen cases of ileus post gastrointestinal surgery that varies from 2-14 days and consume numerous resources with multidisciplinary approach requiring TPN, dietician involvement and increased in length of stay, for this reason I believe it should not be a diagnosis for exclusion. Furthermore, in the current Grouper V10, G02A DRG requires ECCS >=4.5 and Ileus currently only has DCL= 1. One would require an additional four diagnosis complexities for it to be grouped to G02A DRG, I think it is best to leave Ileus with DCL of 1.