NSW GOVERNMENT Health

IHPA Secretariat
Independent Hospital Pricing Authority
Email: submissions.ihpa@ihpa.gov.au

Our ref H21/122364

Dear Secretariat

Thank you for the opportunity to provide comment on the Independent Hospital Pricing Authority's public consultation document, *Development of the admitted care classifications – May* 2021.

Please find attached submission from NSW Health, for your consideration. The submission includes several recommendations related to:

- inclusion of interventions and diagnosis for new health technologies, including engineered cells and gene therapies
- inclusion of classification guidelines and diagnosis codes
- the requirement to uniquely classify certain procedures
- the incorporation of new and retainment of existing standards.

We look forward to receiving further information on results of the consultation.

For more information, please contact Renee Droguett, A/Manager, Stakeholder Engagement and Clinical Variation, Activity Based Management at renee.droguett@health.nsw.gov.au or on 0459 855 663.

Yours sincerely

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IHPA Development of Admitted Care Classifications –

Public Consultation May 2021

NSW Response

Section 3.1.3 COVID-19

1. Are there any additional requirements in coded activity data regarding the classification of COVID-19 that should be prioritised for Twelfth Edition?

NSW supports the ICD-10 emergency use codes for classifying activity related to COVID-19, noting that all cases of COVID-19 adverse effect will be classed to DRG X63 Sequela of Treatment.

NSW supports the COVID-19 ACS to be incorporated into the Twelfth Edition and recommends the inclusion of information regarding sequelae of COVID-19 and complications associated with COVID-19 vaccinations.

Section 3.1.4 Sepsis Update

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

NSW supports alignment of coding practice and definition to Sepsis-3, including expansion of the code set for sepsis to link the causative microbiological agent with the sepsis code. It is noted however that NSW clinicians still use terminology such as biliary sepsis and respiratory sepsis to describe the pathology.

NSW requests that the Twelfth Edition provides classification guidelines on these terms, for example chest sepsis, biliary sepsis.

NSW suggests a change to broaden acute organ failure to include acute organ dysfunction or failure. Clinical advice suggests that sepsis definitions includes patients who have organ dysfunction whilst failure is the extreme state of organ damage.

It is reasonable to suggest that COVID-19 and other viral infections are recognised as potential causes of sepsis, for example COVID-19 codes have a specific code for COVID-sepsis.

Section 3.2.4 Updates relating to new health technology

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?

NSW requests that the following procedures are uniquely classifiable in ACHI:

- insertion of laparoscopic gastrostomy button (pending diagnosis this currently groups to an 801DRG)
- laparoscopic gastrostomy
- insertion gastro-jejunal (GJ) tube

- phage therapy
- aspiration of thin and thick fluid
- Norwood procedure
- unilateral/bilateral Cochlear implant
- umbilicoplasty.

3.2.4.1 Engineered cell and gene therapies

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?

NSW requests IHPA consider the inclusion of a diagnosis code for immune effector cell-associated neurotoxicity syndrome (ICANS). ICANS can be a side effect to patients who receive CAR-T therapy.

Section 3.2.4.2 Stem Cell Transplants - Placeholder codes in ACHI

NSW supports these changes as more accurately reflecting current clinical practice

Section 3.2.6 Consultation and Liaison Psychiatry

5	What are common terms used in clinical documentation to identify the consultation liaison psychiatry (CLP) service?
6	Is there a standard definition used to describe consultation liaison psychiatry (CLP) services?

NSW recommends IHPA consider consultation liaison to be broader than mental health and psychiatry, but applicable across any speciality.

Specifically, in relation to mental health, psychiatry is limiting, and the term should be broader to include other mental health workers. Some Districts/Networks in NSW use terminology such as psychiatric intervention or psychiatry consultation.

Psychiatry and psychology are often separate specialities and as such care should be taken to avoid confusing these terms.

CLP is a mental health service that provides mental health consultation to admitted inpatients in general hospitals (which may or may not include emergency departments, depending on the service). CLP often provides liaison services with different departments such as taking part in case conferences and discussing with staff. There may also be a small outpatient component, but this varies from service to service.

Section 3.3.1 Clarification of ACS 0002 Additional diagnoses

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?

NSW acknowledges that IHPA does not intend to change the intent of this standard.

For clinical coding auditing purposes, the use of this standard and clarification on what to code and what not to code needs to be made clear. In the opinion of NSW clinical coders, recent changes have made ACS 0002 Additional Diagnoses less clear. This lack of clarity leaves coding additional diagnoses open to misinterpretation, or multiple interpretations being adopted. This leads to less consistency in State reporting. ACS 0002 has become difficult for clinical coders to interpret and apply.

NSW suggests that the definition of clinical consultation is more clearly defined. The term *'increased clinical care'* in ACS 0002 implies that clinical consultation needs to be beyond routine. ACS examples should provide common examples of where ambiguity may arise, and that examples state who the documenter is, for example nurse or medical specialist.

NSW suggests terms such as 'major variation', 'routine' and 'stable' should be avoided as they require clinical coders to make a 'clinical' judgement on what is considered 'routine' for a particular condition, or what is 'stable' or a 'major variation' to treatment/intervention. This causes variation in coding and application of the standard.

The Sydney Children's Hospitals Network has specifically requested the addition of more paediatric specific examples.

Section 3.4 Updates in Twelfth Edition resulting from AR-DRG V11.0 development

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

NSW recommends ACS 0044 Pharmacotherapy is updated to provide advice and guidance on pharmacotherapy for HIV, SLE and RA.

NSW further recommends a new standard for pharmacotherapy and the accurate identification of interventions aimed to treat cancer and cancer-related conditions is created within Chapter 2 Neoplasms.

NSW is concerned with the number of standards identified for deletion. Many of the identified standards provide coders with information on conditions or interventions. When a coder is coding a condition or intervention that they are not familiar with or do not often see at their facility, the ACS is reviewed in the first instance to look for guidance/advice. The standards should support all coder levels from entry level (inexperienced) to experienced coders. The ACS are also used to assist with the education of clinicians on documentation and are sometimes used as 'evidence' when explaining coding decisions and code assignments.

NSW recommends consideration be given to the following standards being retained:

- ACS 0109 Neutropenia
- ACS 0241 Malignant neoplasm of lip
- ACS 0402 Cystic fibrosis
- ACS 0521 Admitted patient without sign of mental illness
- ACS 0531 Intellectual impairment/intellectual disability
- ACS 0533 Electroconvulsive therapy (ECT)
- ACS 0627 Mitochondrial disorders
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- ACS 0635 Sleep apnoea and related disorders
- ACS 0733 Haemodilution
- ACS 0742 Orbital and periorbital cellulitis
- ACS 0809 Intraoral osseointegrated implants
- ACS 0943 Thrombolytic therapy
- ACS 1004 Pneumonia
- ACS 1216 Craniofacial surgery
- ACS 1217 Repair of wound of skin and subcutaneous tissue
- ACS 1316 Cement spacer/beads
- ACS 1319 Meniscus/ligament tear of knee, NOS
- ACS 1330 Slipped disc
- ACS 1343 Erosion of knee
- ACS 1348 Spinal fusion
- ACS 1434 Ovarian cysts
- ACS 1437 Infertility and in vitro fertilisation (IVF)
- ACS 1805 Acopia
- ACS 1807 Acute and chronic pain
- ACS 1901 Poisoning

NSW seeks clarification from IHPA on ACS 0531 intellectual impairment/intellectual disability on how the classification would be updated to include advice regarding the capture of 'acquired' intellectual impairment if it is not included within a standard.

NSW notes that ACS 1901 Poisoning standard is important for entry level coders to ensure they understand the difference between poisoning and adverse effects.

NSW notes that ACS 0943 Thrombolytic therapy is used as part of clinician education/meetings.

NSW suggests that changes to spinal surgery could be included to update ACS 1348 spinal fusion to include any new clinical concepts or terms.

NSW notes that ACS 1805 Acopia is used when providing education to clinicians regarding the use of terms such as acopia, which is still documented within a medical record.

NSW suggests that any public submissions currently in the IHPA ACE queue are closed and that suggestions are incorporated in the classification system. In addition, a clinical/procedure database that creates awareness about changes in models of care or new procedures that require classification may benefit the classification development process. Clinicians often provide feedback that the terminology used in ICD-10-AM is clinically outdated, for example epilepsy. Clinicians no longer use grand mal and petit mal as descriptors. Malnutrition is another example, as the clinical definition varies from the classification, and varies between adults and paediatrics.

NSW requests consideration for the following diagnosis codes:

- Hamartoma
- Lymphatic malformation
- specific virus codes for rhinovirus, bocavirus, astrovirus, parainfluenza rather than other specified
- separate codes for Aplastic anaemia pancytopenia

- PANDAS (paediatric autoimmune neuropsychiatric disorders)
- PANS (paediatric acute onset neuropsychiatric syndrome)
- Bulbar palsy
- Cavernoma
- Dravet syndrome is a rare, drug-resistant epilepsy that begins in the first year of life in an otherwise healthy infant and is lifelong.

Section 4.1.1 Complexity Model Revision

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

In NSW, any condition that is documented and meets the definition of ACS 0002 Additional diagnosis will be coded regardless of whether it is included in DRG calculation.

E61.1 Iron Deficiency
NSW seeks clarification on the volume of records that have E61.1 coded without associated external cause codes (indicating drug induced) and whether E61.1 be excluded if there are external cause codes present.

E61.1 iron deficiency may be an indication for same day panendoscopies where a cause may not be known or identified and can be the indication for same day admissions for iron infusions.

K56.7 Ileus, unspecified
NSW seeks clarification on whether the analysis for exclusion of K56.7 has identified where the records have a longer length of stay or a more complicated DRG. NSW recommends further analysis prior to IHPA excluding K56.7.

M62.50 Muscle wasting and atrophy, not elsewhere classifiable, multiple sites
NSW does not agree with the exclusion of M62.50. The increase in this code may be due to the changes to ACS and new NCA rules. For example, NCA published in June 2017 for 1 July 2017 implementation that deconditioning could be coded to M62.50. which was not a code previously available to coders, although this was a prevalent condition clinically, for example post-surgery or with ageing/elderly patients. It is well known nationally of an increase in our ageing population admitted to hospital thus the prevalence of deconditioning cannot be explicitly attributed to coding artefact.

The term deconditioning has steadfastly increased in use by clinicians and is used predominantly in acute care as an appropriate description/assessment of a patient's physical state after a prolonged illness (often after a critical illness), and reason for transfer to either rehabilitation or other non-acute care scenarios. Deconditioning may also be used to classify muscle wasting identified by a dietitian and documented in dietetic progress notes, with a patient placed on a high protein diet, or referred to physiotherapy. Assessment of a patient's risk of malnutrition (muscle wasting is a sign of malnutrition) may also be identified by muscle wasting as both conditions are subject to the same management by dietitians (i.e. high protein diets or supplementation), and it may be that coders are coding both conditions.

D89.8 Other specified disorders of the immune mechanism, not elsewhere classifiable
NSW does not support the exclusion of D89.8. The graphed incidence across all states and with similar increases over time would seem to be in alignment with clinical priorities (as observed by documentation) for an immunosuppressed or immunocompromised patient. The relevance of a transplanted organ does not appear to be the focus after successful transplant, but rather the immunosuppressed state thereafter is of clinical significance in treating and managing the patient. This immunocompromised state requires attention and management in episodes following the initial transplant and is evidenced in the clinical record and hence assigned by clinical coders as per Australian Coding Standards. It is presumed that clinical advice as per IHPA's recommendation would concur with the significance of immunosuppression, and hence would continue to warrant a DCL.

An example of the significance of immunosuppression is provided by an excerpt from a recent admission in NSW where a patient's immunocompromised status was a significant issue during the stay:
"immunocompromised, but will have adequate neutrophils with filgrastim support"
- commenced filgrastim after consult for potential chemotherapy induced neutropenia.
Again, there is increasing documentation of immunosuppression by clinicians as the primary management focus in a transplant patient.

Z06.69 Resistance to other specified antibiotics
NSW does not support the exclusion of Z06.69. In NSW, there are clear reasons for the increase in resistance codes as discussed earlier. An explanation for the decrease in prevalence for this code in VIC after exclusion is perhaps a coding instruction not to assign the 'other specified' code. The resistance codes are crucial given the anonymity in the classification for most MRO's, and as such ACS 0112 should be applied at all times irrespective of any other coding advice. Resistance codes should maintain a DCL in the interest of the complex nature of the organism and its treatment.

P22.1 TTN
NSW recommends further consideration of the exclusion of P22.1 with regards to the assignment of this code to an unqualified neonate versus a qualified neonate. If P22.1 is assigned to a qualified baby where there is associated intervention (such as manual ventilation support) then P22.1 should not be excluded. P22.1 TTN would be considered a significant condition for smaller facilities and would likely require admission to Special Care Nursery.

Section 4.1.1.2 Diagnosis Complexity Level precision

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?

NSW supports the proposed ICD-10-AM code categories for DCL precision in AR-DRG V11.0.

NSW supports the proposed cost groups within the ICD-10-AM code categories for DCL precision in AR-DRG V11.0.

Section 4.1.2 Review of ADRG 801 GIs unrelated to Principal Diagnosis

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?

NSW supports the proposed ADRGs for the General Interventions (GIs) and principal diagnoses, noting the issue already raised by the Sydney Children's Hospitals Network regarding grouping for the insertion of laparoscopic gastronomy button that triggers an 801 DRG when grouped.

Section 4.1.3 ECR

14. Do you support the proposal to create an ADRG specifically for endovascular clot retrieval (ECR) in AR-DRG V11.0?

NSW supports the change for ECR.

Section 4.1.4 Transcatheter aortic valve implantation (TAVI)

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?

NSW supports the changes at points 15 and 16 above.

4.1.5 Peritonectomy

17. Do you support the proposal to create a specific ADRG for peritonectomy?

NSW supports the changes.

Section 4.1.7.2 Error ADRG when reported sex does not match principal diagnosis

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?

NSW supports the change.

Section 4.2.3 Traumatic Spinal Cord Injury

No comment

Consultation question - Other

19. Do you have any additional feedback on the proposed changes for AR-DRG V11.0?

No further comment.