SA Health response to the IHPA Consultation Paper on Development of the admitted care classifications released for public consultation.

Response Overview

South Australia appreciates the opportunity to provide feedback on the Independent Hospital Pricing Authority (IHPA) development of the admitted care classifications consultation paper released on 20 May 2021. SA Health has developed the following response through consultation with stakeholders in the Department for Health and Wellbeing (DHW) and the Local Health Networks (LHNs). Responses to the consultation questions are summarised in this submission.

Consultation Questions

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

Suggestions from LHNs have been made to implement a code to capture if the patient has had their 1st dose of the vaccine or their 2nd dose of the vaccine to tie in with U07.7 Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use].

A query was received regarding whether U06.0 should be assigned in the case of tests being performed to ascertain if a current inpatient has previously been infected with COVID-19, rather than an acute/current infection, or should another code be activated to capture this concept.

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

There is support amongst LHNs to align the coding practice of sepsis with the Sepsis-3 definition due to clinical uptake and preference.

3. Most interventions in the admitted patient 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?

Currently there are no new interventions incorporating new health technology requiring unique classifications.

A enquiry was received seeking clarification about the appropriate procedure code for Ligasure device – a new method of haemorrhoidectomy which uses a combination of pressure and radiofrequency to ligate vessels. There is a query as to whether this requires a unique code or should it be included in a current intervention code.

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 additional requirements.

5. What are common terms used in clinical documentation to identify the consultation liaison psychiatry (CLP) service?

A response provided from one LHN described the use of Standard Allied Health or Psychiatry Progress Notes. Other terms used were include Liaison Psychiatry, Consultation Liaison Psychiatry and Consultation Liaison Mental Health Services.

6. Is there a standard definition used to describe consultation liaison psychiatry (CLP) services?

There are reservations surrounding the proposal to introduce a code to identify CLP assessments due to concerns about how a CLP consultation would be documented in patient progress notes and the burden it places on coders to identify these consultations. It sets an undesirable precent which encourages other specialities to request specific codes to identify their services for funding purposes.

There is no single standard of common terms identified at present amongst LHNs and as such there is likely to be an array of terms used with likely variation between services. The consensus from LHNs is that clarification is required and further input from current mental health services / sites would be beneficial.

LHNs seek clarification regarding:

- What services are intended to be included/excluded as CLP? e.g. would a Case Conference led by a Consulting Psychiatrist be a CLP?
- What commonly used names should and should not be included as lead terms to enable the assignment of a CLP intervention code?
- What are the data capture/reporting/processing requirements for MH NBEDS & the AMHCC, and for related costing purposes.

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?

- Coders face the challenge of determining what is the standard protocol for each condition and must make decisions regarding what is increased clinical care versus routine or preventative treatment. Other problems can arise from interpretation of:
    - Commencement, Alteration or Adjustment of Therapeutic Treatment – need clear definitions of what constitutes a “minor adjustment to the diagnostic work-up or the care plan” and “a major variation to the care plan for another condition”
    - Increased Clinical Care – the term “routine” could be misinterpreted as skill levels, case complexity and treatment protocols may vary between sites.
    - Incidental findings and Conditions – this can be open to interpretation
    - Clinician education may be required to ensure Additional Diagnoses listed in the Discharge Summary meet ACS 0002
- Significant work needs to be done in clarifying the use of documentation within an EMR due to the innate ability for integrated long-term, multi-functional use of the record. This represents significant challenges to identify documentation which is relevant for Coding and falls within the scope of a particular episode of care due to the over-arching use of the systems.
- Barriers to the assignment of appropriate activity codes due to the wording used within ACS0002 and ACS0010 may also be sourced from:
    - Difficulty in getting documentation of interactions and findings occurring in electronic consultations (eg telephone or video)

- Clinician remote access to review a patient's records may be applicable for use of code assignment with ACS0002, and

- Integrated system functionality (i.e. documentation restrictions may not support the identification of inpatient activity allocated within outpatient documentation that support clinician training and use of the Electronic Medical Record)

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

Alternative methods could be considered in assessing unmet needs, for example, the ICD-10 code for cachexia (wasting of the body due to chronic illness) could be used to identify unmet inpatient palliative care needs. People affected by cancer and other progressive life-limiting illnesses in the final stages of their illness almost always have cachexia, making it a potentially suitable systems level proxy for palliative care need. Utilising the new ICD-10 code for cachexia [R64] in the presence of a known progressive chronic illness could be used to identify inpatients who require palliative care and who received palliative care. This would help to identify the cohort of inpatients with potential palliative care needs who missed out.

Other concepts not able to be classified include frailty, functional decline and carer stress as documented reasons for admission.

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).

There is support to exclude the majority of proposed codes with the exclusion of the following diagnoses:

a. M62.50 Muscle wasting and atrophy due to this being a significant manifestation of certain conditions which is often the primary reason for admission and resource intensive to treat in an acute setting. Agree with the inclusion of this in future sub-acute frailty setting.

b. Z06.51, Z06.52 and Z06.69 Resistance codes due to the additional resources used such as Infectious Disease specialists (and higher cost of multiple antibiotic treatments) incorporated in treating these infections.

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

No additional exclusions identified.

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

There was support for the proposed ICD-10-AM code categories for DCL precision.

12. Do you support the proposed cost groups within the ICD-10-AM code categories (see Appendix C) for DCL precision in AR-DRGV11.0?

The proposed cost groups are supported generally however, it has been suggested the following codes should not be considered low cost due to the often-lengthy admissions and high resource use involved in treatment.

a. P07.31 Preterm infant, 28 or more completed weeks but less than 32 completed weeks
b. P07.32 Preterm infant, 32 or more completed weeks but less than 37 completed weeks

13. Do you support the proposed ADRGs for the General Interventions (GIs) and principal diagnoses outlined in Appendix B.1 and B.1 on the IHPA website?

The proposed ADRGs are supported, however a question was raised, whether 35321-06 [768] Transcatheter embolisation of blood vessels, pelvis should be considered for another ADRG other than W04 and X06, due to use in female reproductive organ procedures and chronic abdominal pain treatments?

14. Do you support the proposal to create an ADRG specifically for endovascular clot retrieval (ECR) in AR-DRGV11.0?

Proposal supported

15. Do you support the proposal to reassign percutaneous cardiac valve replacement (PCVR) interventions in ADRGs F03CardiacValve Interventions WCPB Pump W Invasive Cardiac Investigation and F04Cardiac Valve Interventions W CPB Pump W/O Invasive Cardiac Investigation to F19Trans-Vascular Percutaneous Cardiac Interventions?

Proposal supported

16. Do you support the proposal to remove PCVR interventions from ADRG F05CoronaryBypassW Invasive Cardiac Investigation and F06CoronaryBypass W/O Cardiac Investigation?

Proposal supported

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

Proposal supported

18. Is there support for the removal of the sex conflict test in AR-DRGV11.0 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?

Proposal supported and welcomed

19. Do you have any additional feedback on the proposed changes for AR-DRGV11.0?

No further feedback