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Dear IHACPA Secretariat,

Re: *Development of ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 – Consultation Paper*

The Health Information Management Association of Australia (HIMAA) welcomes the opportunity to respond to the *Development of ICD-10-AM/ACHI/ACS Thirteenth Edition and AR-DRG Version 12.0 – Consultation Paper*.

HIMAA is the professional association for health information management professionals in Australia. Our members work in a variety of roles within and supporting the healthcare system, with primary occupations being qualified Health Information Managers and Clinical Coders.

HIMAA recognises the importance of the classifications used for admitted patient care, the quality data used to underpin them, and the workforce required to effectively implement and use them.

HIMAA's response to the consultation paper has been prepared with input from subject matter experts from HIMAA's Clinical Coding Community of Practice (CCCOP).

Please find attached the responses to the questions posed in the Consultation Paper. We welcome the opportunity to further clarify any aspects of our submission.

Kind regards

Sallyanne Wissmann
Chief Executive Officer
[redacted]
Health Information Management Association of Australia Ltd

1. Do you agree with the proposed changes to capture new, missing, or important public health considerations in ICD-10-AM?

The CCCOP has the following responses to the proposed changes for ICD-10-AM Thirteenth Edition:

- Creation of a unique code for *postural orthostatic tachycardia syndrome [POTS]* as it is currently classified to a residual code for other disorders of autonomic nervous system
    - Support.
- Expansion of R10.2 *Pelvic and perineal pain* to enable distinction between the male and female pelvis, completing the work commenced in Twelfth Edition to eliminate the need to use sex as a classification variable in the AR-DRG classification, i.e. this facilitates the removal of the last remaining sex edit in AR-DRGs
    - Support, alignment with ICD-11 codes would be particularly useful here.
- Removal of *Excludes* note to support R45.81 *Suicidal ideation* being assigned in addition to a mental health condition
    - Support, given the public health interest in this area this is an important change to progress.
- Creation of R45.82 *Homicidal ideation*
    - Support, however, the CCCOP suggests clinical advice is required to inform an appropriate *Excludes* note for conditions strongly associated with/has features that include homicidal ideation, such as certain personality disorders classified to F60 such as psychopathy.
- Expansion of U73.8 *Other specified activity* to enable identification of intentional self-harm by poisoning or injury
    - Support.
- Creation of Z72.7 *Use of vaping device*
    - Support, suggest that a coding standard may be required to ensure the desired capture of this activity as the current location of this code would require it to meet ACS 0002 criteria which defeats the purpose of collecting the use of the vaping device. Alternatively, if there are body systems where vaping has already been shown to impact health, a Code Also instruction may be appropriate (e.g. at Chapter 10 *Diseases of the Respiratory System* and Chapter 9 *Diseases of the Circulatory System*).
- Consideration of codes to capture concepts relating to voluntary assisted dying in admitted episodes of care
    - Whilst countries such as Canada have a code for this (Z51.81 *Assistance in dying*) the use of ICD-10-CA is broader than ICD-10-AM. The CCCOP also note that this concept has not been accepted into ICD-11. If it does proceed, there would be utility to have a Code first for the condition likely to cause death or intolerable suffering (i.e. eligibility requirements for accessing assisted dying services)
    - The location of this code should also be cognisant of when it should be assigned. If it's intended to capture any patients receiving assistance in dying whilst admitted, then perhaps it's better suited as an ACHI code with the principal diagnosis code

representing the condition likely to cause death or intolerable suffering. If assistance in dying is something that can be something that isn't the focus of care for an admission, then it should be an exception from requiring to meet ACS 0002 criteria.

- Broadening of terminology and the inclusion of more commonly used coagulation assays for anticoagulant monitoring as this is currently limited to international normalised ratio (INR).
    - Support.

2. Are there any additional considerations for the capture of social factors that should be considered for Thirteenth Edition (or a future edition)?

The CCCOP supports the capture of factors that influence and determine health and equity of access to services.

The CCCOP notes that without a specific implementation date for ICD-11 the following factors warrant a code to identify them, and warrant implementation in Thirteenth Edition, specifically:

- Problems related to forced migration, an important factor in war and impacts of climate change (both long term and from natural disaster), that impacts on access to services and has the potential for disconnected care.
- Problems related to digital literacy and the inability to locate or utilise self-care options such as health apps, patient monitoring etc which may explain variation / the need for patients to be admitted that would not ordinarily be admitted.

3. Are there other new interventions that should be uniquely classifiable in ACHI for Thirteenth Edition (or a future edition)?

The CCCOP strongly recommends the inclusion of a code to capture the activity that relates to priority populations such as First Nations people and people with a disability. Therefore, the following codes are requested from the CCCOP for inclusion in ACHI for Thirteenth Edition, a code to identify Aboriginal Liaison Services have engaged with an admitted patient. This has the potential to assist evaluation into these services against patient outcomes.

It is acknowledged that there is only so much development work that can be undertaken per edition. However, the CCCOP also suggests IHACPA review high frequency, low specificity codes to ensure the statistical and evidence-based nature of the classification development is maintained.

4. Are there any additional considerations for organ, tissue and cell and procurement and transplantation that should be prioritised for Thirteenth Edition?

The CCCOP notes that there may be benefit in rethinking the amount of specificity in the ICD-10-AM code set given the details and expansion of the ACHI code set for procurement and transplantation. Recognising the constraints of the AR-DRG classification, it may be pertinent to reconcile what is required for principal diagnosis in ICD-10-AM for the MDC versus what could be used in ACHI to determine the ADRG.

The CCCOP suggests that an ICD-10-AM code for multiple conditions (i.e. *Donors of multiple organs and tissues*) is not an ideal code to create, especially given the differences in cost and nature of organ donation versus tissue donation. If this code were to go ahead, guidance should be instated to ensure that major organs were assigned before this code.

5. Are there any additional considerations for the implementation of cluster coding that should be prioritised for Thirteenth Edition?

The CCCOP supports the implementation of cluster coding, the staged approach, and the pilot. Noting that clinical coding is taught through the vocational education and training (VET) sector and the tertiary sector, the CCCOP suggests that education resources are designed to support incorporation into curricular. This will assist workplaces with continual education of cluster coding and support workforce ready graduates that contribute to the quality of clinical coded data.

For the VET sector, providers of the Diploma of Clinical Coding registered with the Australian Government are available at https://www.yourcareer.gov.au/learn-and-train/courses/HLT50321.

For the university sector, the Australian universities known to be teaching clinical coding include:

- La Trobe University
- Queensland University of Technology
- Western Sydney University.

The CCCOP also suggests that IHACPA ensures that coding software vendors, patient administration system vendors, and AR-DRG vendors have sufficient information prior to the implementation of Thirteenth Edition to design and test solutions for cluster coding.

6. Are there any additional considerations for the implementation of ACS 1904 Complications of surgical and medical care that should be prioritised for Thirteenth Edition?

The CCCOP support making ACS 1904 clear and easy to apply and strongly suggest that IHACPA ensure that the version of ACS 1904 proposed for Thirteenth Edition achieves the outcomes that it initially set out to achieve. Similar to the approach for Twelfth Edition ACS 0002, it's recommended that all subjective terms are explained or removed to ensure consistent application.

Given the impact on safety and quality reporting, an important aspect under the National Health Reform Agreement, the CCCOP supports a pilot of the standard prior to publishing Thirteenth Edition.

The removal of the residual codes is mostly supported; however, the CCCOP recommends an impact assessment of the changes to ensure a mitigated and transparent impact on the implementation of Thirteenth Edition.

7. Are there any additional considerations for difficult intubation that should be prioritised for Thirteenth Edition?

The CCCOP supports the new code for difficult airway for intubation. It may be pertinent to exclude a history of difficult airway as this is often documented for patients with specific anatomical features of the airway.

8. Are there any additional considerations in relation to the standardisation of the ACS that should be prioritised for Thirteenth Edition?

The CCCOP supports IHACPA in reducing the number of Australian Coding Standards where these can be incorporated into the classification conventions. According to principles of evidence-based and transparency in the Governance Framework, there is an opportunity for IHACPA to be transparent in publishing the impact of data of removing a standard and its impact on the coded data thereafter. It is anticipated that this analysis would demonstrate that this approach to reducing the number of ACS is effective.

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

The CCCOP supports the principles outlined in the Governance Framework, and noting the Transparency principle, recommends that IHACPA reports how they have maintained alignment with the Governance Framework for the development of Thirteenth Edition.

The CCCOP appreciates the limitations associated with incorporating the MBS into ACHI. To support the wider users of ACHI coded data, it is suggested that the map from MBS to ACHI for Thirteenth Edition includes the MBS items published between what is incorporated (i.e. March 2023) to when it is implemented (i.e. June 2025).

10. Do you support the proposed guiding principles for intervention type?

The CCCOP supports the proposal to clarify what kind of ACHI codes inform the grouping of an episode to the intervention partition. Clarity for clinical classifications includes making sense from a clinical perspective – this is not clearly represented in the guiding principles as it maintains too much focus on the structure of the existing AR-DRG classification rather than why an intervention fits within the guiding principle category.

Maintaining the term “GI” contributes to overly complex, non-intuitive descriptions of the principles. The way that the principles are written currently does not lend itself to supporting clinical advice to make clinically informed decisions. If it’s intended that clinical advice is the arbitrating factor for determining an ACHI code’s category, then the principles need to be written in a different way that prioritises a clinical understanding.

In an environment where fewer people accurately understand the mechanisms of the AR-DRG classification, it is not recommended to further complicate the system prior where it cannot be simply explained nor understood.

11. Do you support the proposed amendments for ACHI code intervention types, listed at Appendix A, to align with the proposed guiding principles for intervention type?

The CCCOP notes that the problem, for which the proposed solution aims to remedy, is not clearly articulated. The CCCOP believes that the proposed partial implementation is not evidence-based, nor does it aim for stability, as encouraged by the Governance Framework.

The CCCOP believes that this work requires dedicated resources to see its full implementation in a single version to ensure impact is well understood. Noting the amount of work, and the potential implementation of ICD-11 in coming years, it may be the opportunity to review a major change to the AR-DRG classification system in tandem.

12. Do you support the creation of ADRG U69 Mental and Behavioural Disorders Associated with the Puerperium in MDC 19 Mental, Behavioural and Neurodevelopmental Disorders, using the ICD-10-AM codes listed in Appendix B?

The CCCOP notes the analysis that the reasoning is sound, the CCCOP supports this evidence-based change.

13. Do you support the disaggregation of ADRG O66 Antenatal and Other Admissions related to Pregnancy, Childbirth and the Puerperium and creation of four medical ADRGs in MDC 14 Pregnancy, Childbirth and the Puerperium, found in Appendix C?

See response to Question 14.

14. Do you support the grouping of ICD-10-AM codes to form the four new medical ADRGs in MDC 14 Pregnancy, Childbirth and the Puerperium, found in Appendix C?

The CCCOP appreciates the text description of the ADRGs O67, O68, O69 and O70. The CCCOP recommends that these are incorporated into AR-DRG Version 12.0 in a similar way that the ICD-10-AM and ACHI classification systems have *Instructional notes*. These descriptive definitions would assist users (and the developer) of the classification to ensure the logic defining the ADRGs aligns with the codes and logic selected.

The analysis and reasoning of this proposal is sound, the CCCOP supports this evidence-based change.

15. Do you support the grouping of mastitis and other infections of the breast to ADRGs O04 Postpartum and Post Abortion with General Interventions or O61 Postpartum and Post Abortion without General Interventions, regardless of attachment difficulty?

The CCCOP notes that while this seems logical, the consultation paper has not provided an evidence base for stakeholders to truly support or not support this proposal.

16. Do you support increased DCL precision for the 25 diabetes mellitus codes listed in Appendix D?

The CCCOP supports, and welcomes, the DCL precision proposal.

17. Do you support the proposal to create ADRG A41 Posthumous Organ Procurement?

The CCCOP notes that the barriers to data collection on posthumous organ procurement are not influenced by a DRG, but rather jurisdictional policy on whether to report that nationally.

The CCCOP believes there is merit in more than one ADRG for posthumous organ procurement, noting the types and complexity of organ harvest arrangements. The consultation paper recognises that the pre-MDC is defined by intervention codes; however, grouping all the disparate ACHI procurement codes into a single ADRG seems incongruent.

If this change is to go ahead, the CCCOP notes that the scope of AR-DRGs should be amended to including the posthumous organ procurement care type.

18. Do you support the proposed ADRGs for episodes that currently group to ADRG 801 General Interventions (GIs) Unrelated to Principal Diagnosis as outlined in Appendix E?

The CCCOP suggests that these amendments do not require public consultation, given the lack of evidence for stakeholders to support or not support the changes, and their technical nature.

19. Do you have any additional feedback on the proposed changes for AR-DRG V12.0?

The CCCOP supports the principles outlined in the Governance Framework, and noting the Transparency principle, recommends that IHACPA reports how they have maintained alignment with the Governance Framework for the development of Version 12.0.