20 November 2023

To: **IHACPA – Comment on ACS 13th Edition and AR-DRG Version 12.0**

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Dear IHACPA,

Some quick thoughts on your consultation from a Medical Administrator who does some work in this area.

The guiding principles should include:

P1: Combination of Classification/Coding and Funding should not create an incentive for suboptimal care.

P2: ACS/AR-DRG should ensure future versions are improvements in the relationship between DRG complexity and underlying cost of care.

Examples of some issues include:

Multi-resistant organisms with the related costs of drugs and impact of care through isolation and contact precautions is recognised as a growing issue for healthcare. The approach to remove DCCL values in DRG 11 was an inappropriate response to growth in coding of minor resistances. The coding standards and DRG system should recognise significant resistance patterns like the ESBL code for CRE, Amp C (like ESBL), VRE and MRSA where the requirement is contact precautions/isolation. This change would fail P2 above as the cost of this issue is rising and should be recognised. Similar comments could be made about Immunosuppression and impact on cost, how was the decision made to take this to a DCCL of zero in DRG V11? Was this clearly put to the clinical advisory group that IHACPA considers that this has no impact on the cost of care? Perhaps just a single ICD code for the presence of a MRO that requires contact precautions and this code has a DCCL to avoid the 'multiplier' effect of DCCL values with every type of resistance code.

Early identification of Sepsis is important to ensure care is commenced where it is suspected. The HAC penalty system penalises hospitals that correctly identify suspected sepsis and commence treatment based on this suspicion. This leads to it being referred to by other names like 'Bacteraemia' or not being documented when it should be documented. The hospitals with higher levels of documented 'suspected sepsis' are taking the right approach to early identification and action and are likely inappropriately penalised for this.

More severe clinical conditions that require higher levels of care should attract the same or higher DCCL values and not just be a random number generator. For example, in 65 DRGs in DRG version 11 Septic Shock (R57.2) has a lower DCCL than Hypotension (I95.9). With Septic shock normally requiring inotrope infusion it is a normally a significantly more complex form of hypotension to manage.

There are many studies on conditions like Pressure Injuries impacting on the cost of care and the HAC penalties reflect this if it evolves in hospital. Why do 46 DRGs in version 11 not have DCCL values > 0 for conditions like this that drive significant addition costs? One option would be if the discount ratio of 0.86 used for progressive discounting of DCCL values was reduced to a smaller value (?0.9), this would enable more of these conditions to be given a DCCL score where these conditions are expected to increase costs and this change would extend the range of the thresholds used to separate different levels of complexity. The current level of 0.86 discounts the value of a DCCL point so much in the current version a threshold of above 4.5 is problematic. Other alternatives also possible.

The national definition of an admission is the time of a clinical decision to admit and care provided after that time is eligible to be coded within an episode. There are different State policies and a National definition. For Rural hospitals with very sick patients the safest location for the patient is frequently within the Emergency Department where medical supervision is highest. Currently there is a set of definitions (combination of State admission policies and IHACPA and National Definitions) that creates a strong financial incentive to move patients from the safest location so their care is funded would fail the proposed principles. This counting issue needs to be balanced against variation in "excessive" classifying of patients as admitted. One solution to this issue would be:

- National Definition with clinical decision to admit remains.
- Where ED "first seen time" to linked to episode Discharge time is less than ?6 ?8 hours – zero NWAU unless departure status is a death or a transfer to another hospital.

This ensures that complex care at the start of an admission can be equally captured across the health system and is not a function of if the hospital has access block preventing a patient from crossing a line to an "inpatient" area.

Within other coding standards like the USA there are guidelines like the ones below. In the case of CKD and hypertension, as the CKD drives sodium retention and fluid retention (and thence hypertension) – the physiology linking conditions is recognised within the standard. If increased linkage between codes is to be adopted then the coding standards should recognise common links and enable coders to use the standard rather than raise large number of coding queries to clinical teams.

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2) Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.

2) Osteoporosis with current pathological fracture

Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

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