Private Healthcare Australia
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Australian Health Service Alliance

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Professor Richard Madden
Director
Australian Consortium for Classification Development (ACCD)
c/o National Centre for Classification in Health
Faculty of Healh Sciences, Cumberland Campus C43T
The University of Sydney
PO Box 170, Lidcombe NSW 1825

Dear Prof. Madden

Re: ARDRG V9.0 Public Consultation – Major Updates
Feedback from the private sector

We are grateful for this new initiative (public consultation) to ensure that the private sector has the opportunity to provide constructive feedback regarding the major updates in the development of ARDRG v9.0. Given this, we have opted to provide a formal letter in addition to the brief commentary we can make via the ACCD website.

In general, we agree with many of the changes to the proposed classification, such as the principles to reduce the number of pre-MDC DRGs, changes to paraplegia/quadriplegia grouping logic for surgical cases, and the new DRG for bronchiectasis. However, we will comment only on those areas of concern to the private sector.

Use of DRGs in the Private Sector
As you would be aware, DRGs are increasingly used as the basis of funding in the private sector and also underpin robust benchmarking. There is an increasing and appropriate trend to clinically benchmark public and private hospitals together, underpinned by the DRG classification system.

It is our view that development of DRGs should be based on activity over all facilities i.e. in both the public and private sectors. It is acknowledged this may present some challenges in terms of costing data, although not LOS data, however this should not prevent consideration of private sector data as part of the development of ARDRG v9.0 and more detailed consideration in the development of later DRG versions.

Of particular concern is that ACCD appear to be pressing on with some changes that will have a significant effect on the private sector, which is evidenced in PHDB or HCP data. The fact that current private sector cost weights are not available is not a valid reason to press on with changes that significantly affect us.

There is precedent for private sector data contributing to DRG development work (for example, refer to the last sentence in the Acknowledgements section of Volume 1 of the AR-DRG v5.0 Definitions Manual.

It is our view that the term “current DRG version” includes only those where there is co-existing robust cost weights. Given that the most recent published cost weights in the private sector are in AR-DRGv6x, we consider this to be the most current version in the private sector. We do acknowledge that private sector costing study participation rates are an issue, and that IHPA are taking steps to address this.

As reported at a recent DTG meeting, AHSA presented feedback from all health funds, and can confirm that by 1/7/2017 there will be only one fund remaining on AR-DRGv42, and this will be for less than 10 individual contracts. It is therefore prudent to put to bed the myth that “all health funds are all on DRGv42”.

Proposed Changes to DRG Classification for AR-DRGv9

2.1 Pre-MDC ADRGs:

While comfortable with most of the suggested changes, we are strongly of the view that DRG A12 *Insertion of Neurostimulator device* remain a separate DRG. A12 is a common DRG in the private sector e.g. Private Hospital Data Bureau (PHDB) data for 2013-14 states there were 2,844 cases in this DRG. Over the last two years the number of cases of A12Z in AHSA data has increased by 44.3% hence we project that in 2015-16 there will over 4,000 cases in this DRG in the PHDB dataset. It is our view that insertion of this device is the primary driver of the cost and LOS of cases in this DRG irrespective of the underlying diagnosis and therefore it is inappropriate to abolish this DRG at least without detailed analysis of private sector data. To do this would be quite inconsistent with the principle of “Clinical coherence” espoused at” Section 1.1 Background” at page 4 of the consultation paper.

We accept that Pre-MDC is not the ideal location for this ADRG, and the principles which are being applied to move such DRGs that do not fit in this category; however, that does not mean that this DRG should be removed all together. If it must be removed from Pre-MDC, we suggest that it be renamed and moved to the neurological MDC.

2.2 A06 Tracheostomy and/or Ventilation >= 96 hours:

The suggested changes are sensible and reflect the differences between relatively short term ventilation and longer term ventilation which necessitates fashioning of a tracheostomy which is typically done after about fourteen days of ventilation by an endotracheal tube. However in saying this, we would encourage the creation of a detailed and robust national definition of Mechanical Ventilation particularly in the area of weaning when a tracheostomy to facilitate long term ventilation has been fashioned. It is anticipated that the new A13 DRG will be significantly higher weighted than the new A14 DRG, hence a very precise definition of what is MV is appropriate generally.

2.4 ADRGs in the “Other” partition:

There are two proposed changes which we questions the appropriateness of:

a) Combining the current DRGs G46 complex endoscopy, G47 Gastroscopy and G48 Colonoscopy into one new DRG G49 Gastroscopy and Colonoscopy.

   The area of particular concern related to the abolition of G46.

   - This reflects the situation in which both a colonoscopy and a gastroscopy are done at the one time.
   - This is significantly more resource intensive than either a colonoscopy of a gastroscopy in isolation hence merits a separate DRG.
   - This would also be quite inconsistent with the principle of “Clinical coherence” espoused at” Section 1.1 Background” at page 4 of the consultation paper.

b) Combining of L40 Ureteroscopy, L41 Cystourethroscopy for urinary disorder, sameday, and L42 ESW lithotripsy into two new DRGs distinguished by with and without urinary calculus.
- L42 should remain as a separate DRG.
  - we have difficulty in envisaging when ESW lithotripsy would be used appropriately without the presence of renal calculi,
  - ESW is typically performed in a dedicated facility and payment for this DRG in the private sector frequently reflects the capital cost of the lithotripter and associated facilities.
- This again be quite inconsistent with the principle of "Clinical coherence" espoused at" Section 1.1 Background" at page 4 of the consultation paper given – the lithotripter as very different clinically to non-lithotripter and sufficiently common to merit their own DRG.

2.6 AR-DRGs with a lack of clinical distinctiveness:

We agree that splitting the current I03 DRG stem into separate stems based on trauma (particularly fractured neck of femur cases) and non-trauma will improve homogeneity based on clinical principles irrespective of other issues. The one aspect of this change that we are concerned about is the definition of trauma and its temporal proximity to the time of surgical intervention. This needs to be clear and comprehensive to avoid potential misunderstandings.

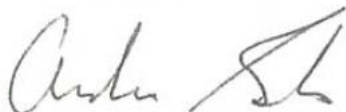
Conclusion:

In summary:
- We strongly oppose the removal of A12 Insertion of Neurostimulator
- We strongly oppose the merging of DRGs G46 complex endoscopy, G47 Gastroscopy and G48 Colonoscopy into one new DRG G49 Gastroscopy and Colonoscopy
- We strongly oppose combining of L40 Ureteroscopy, L41 Cystourethroscopy for urinary disorder, sameday, and L42 ESW lithotripsy into two new DRGs distinguished by with and without urinary calculus.

The private sector has made a concerted effort to upgrade to the most current AR-DRG version (with cost weights), which is 6x. Unfortunately, even once cost weights are available, if ACCD does not design a classification system that is fit for purpose for both the public and the private sector, it will be deemed virtually unusable for payment purposes. This is particularly the case for endoscopy, given the large volume in the private sector.

If you have any questions regarding this submission, please contact either Dr Brian Hanning, Medical Director AHSA email brian@ahsa.com.au or Nicolle Predl, Senior HIM email nicolle@ahsa.com.au.

Yours sincerely



Andrew Sando
Chief Executive Officer
Australian Health Service Alliance

Dr Rachel David
Chief Executive Officer
Private Healthcare Australia

cc. James Downie, CEO, IHPA
Vera Dimitropoulos, Executive Manager, NCCH