Funding Models Forum

Admitted acute – WIES24

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In 2017-18, the WIES24 model will apply to:

- Public and Private in public WIES (PP WIES)
- Department of Veterans’ Affairs (DVA WIES)
- Transport Accident Commission (TAC WIES)
- National Bowel Cancer Screening Program WIES (NBCSP WIES)
From 1 July 2017, there will be a specific National Bowel Cancer Screening Program (NBCSP) WIES target for all public health services that provide colonoscopy.

This will be separate to the other WIES targets that a health service receives and activity will be recalled/paid to actual activity.

Marginal policy does not apply to NBCSP WIES. NBCSP WIES cannot be converted to PP WIES.

NBCSP admitted patient activity must be reported as having a funding arrangement code 8 (bowel screening) in the VAED. It is expected that most of the patient activity will be grouped to Vic-DRG8.0 G48B (Colonoscopy, Minor Complexity) or G46B (Complex Endoscopy, Minor Complexity).
Victorian Admitted Episode Dataset (VAED): Criteria for Reporting

Changes to the VAED Criteria for Reporting for 2017-18 include:

- Criterion for Admission ‘O’ to include patients admitted to a designated mental health service regardless of legal status.
- New Criterion for Admission ‘X’ : ED Short Stay Observation Unit.
- Addition of 81 procedure codes to AAPL.
- Addition of 38 procedure codes to the NAAPL.
- Removal of 260 procedure codes due to the development of new codes that better represent the procedure.
- Transfer of 7 procedure codes from NAAPL to AAPL
- Transfer of 5 procedure codes from AAPL to NAAPL.

(N)AAPL = (Not) Automatically Admitted Procedure List
WIES24
Key changes in 2017-18

The key changes applied to WIES24 are as follows:

- Refreshing the base WIES model
- Adjustment to Thalassaemia co-payment
- Victorian AR-DRG for Endovascular Clot Retrieval (ECR) B02Y
- Adjustment for 10th edition ICD-10-AM coding
- Short Stay Observation Units (SSOU) weights for eligible DRGs
- Victorian modification to AR-DRG8.0 (Vic-DRG8.0)
The annual refresh of the base WIES model includes:

- The latest available cost data (2015-16 cost data)
- DRG boundaries based on the latest 5 years of activity data
- Medical Indemnity costs
- Normative pricing for hips and knees
- Cost modelling for Lions Eye Donation Services
A thalassaemia copayment was introduced to the WIES model in 1997-98 (WIES5) to recognise that thalassaemia cases are significantly more expensive than other cases within the same DRGs.

A review of the latest available patient level cost data (2015-16) shows that cost differences have decreased between thalassaemia cases and other cases within the same DRGs.

The thalassaemia copayment has accordingly been adjusted to maintain alignment with reported costs.

Under WIES24, there will be a reduction in the thalassaemia copayment from 0.2648 (WIES23) to 0.1089 (WIES24).

This reduction will bring cost recovery closer to 100 per cent.
A new Vic-DRG8.0 **B02Y Endovascular Clot Retrieval** will be implemented from 1 July 2017 to recognise the highly specialised resource requirements that are needed to perform Endovascular Clot Retrieval (ECR).

**B02Y Endovascular Clot Retrieval** will be assigned for episodes that:

- originally group to the adjacent AR-DRG8.0 of B02 Cranial Procedures **AND**
- include a tenth edition ICD-10-AM principal or secondary diagnosis code of I63.x, I64, I65.x or I66.x **AND**
- include an ACHI tenth edition procedure code of 90235-00 *Embolectomy or thrombectomy of intracranial artery.*
The new ECR cost weight will fund activity reported by the ECR sites of:

- Melbourne Health (24/7 ECR service), Monash Health (24/7 ECR service), Austin Health, Alfred Health and St Vincent’s Hospital Melbourne

The new ECR cost weight will achieve a fairer cost recovery for:

- episodes where ECR is performed.
- other (non-ECR) episodes within the Cranial Procedures Adjacent DRG.

Patients with ECR that are currently grouped to A06 Tracheostomy and/or Ventilation >=96hour will continue to be grouped to this Adjacent DRG as it results in a more appropriate cost recovery for these patients.
WIES24
Short Stay Observation Unit (SSOU)

A new (separate) cost weight for admissions to SSOUs will be introduced from 1 July 2017 to make WIES funding more equitable and sustainable.

Two new columns are introduced into the WIES24 cost weight table:
- A column indicating DRG eligibility
- A column containing a single SSOU cost weight for each eligible DRG

SSOU cost weights have been developed for 163 DRGs that have between 10 per cent and 90 per cent SSOU activity:
- DRGs with < 10 per cent of SSOU activity do not have adequate SSOU volumes to warrant a separate cost weight.
- DRGs with > 90 per cent of SSOU activity will have their cost weights largely determined by SSOU activity.
Episodes funded by the SSOU cost weights are:

- eligible for WIES funding; \textit{and}
- have a first accommodation type S (SSOU); \textit{and}
- no second accommodation type; \textit{and}
- an accommodation type on separation S (SSOU); \textit{and}
- are either a sameday, oneday or multiday episodes.
Short Stay Observation Unit

The majority of SSOU activity is reported as same day or one day episodes.

The introduction of SSOU cost weights will:

• better align revenue with costs for SSOU patients (from 127% to 100% cost recovery)

• result in a more equitable funding arrangement for non-SSOU episodes in SSOU-eligible DRGs
In 2016-17, AR-DRG version 8.0 (DRG8.0) was implemented both nationally and in Victoria.

Historically AR-DRGs use patient diagnoses, procedures and hospital administrative variables to determine a patient’s DRG outcome.

However, under AR-DRG8.0:

- Significantly more adjacent DRGs are split on diagnostic complexity than was the case in previous DRG versions.
- Both AR-DRG versions 7.0 and 8.0 retain the same number of non-error adjacent DRGs (i.e. 403), however the number of adjacent DRGs split on diagnostic complexity increases from 167 in AR-DRG7.0 (41%) to 315 in AR-DRG8.0 (78%).
Under AR-DRG8.0 (continued):

- Less reliance is placed on administrative variables to split adjacent DRGs (e.g. same day episode status, age, mental health legal status)

- Principal diagnosis is now included in the Adjacent-DRG splitting methodology (previously it was excluded)

- Approximately 12,500 diagnosis codes can influence the DRG outcome (complexity split) compared to only 3,200 diagnosis codes in past AR-DRG versions)
Implementation of AR-DRG8.0 was expected to increase the reporting of diagnosis codes for patient episodes (i.e. to better measure patient complexity).

However, the unexpected consequence of implementing AR-DRG8.0 has been the magnitude of change in the profile and number of diagnosis codes reported.

This has resulted in a greater-than-expected

- proportion of episodes being escalated up the DRG complexity hierarchy (e.g. from DRG B03B to B03A)

- volume of WIES being generated by a change in the reporting of diagnosis codes
From 1 July 2017 a Victorian modification to AR-DRG8.0 will be implemented within the WIES24 model to maintain funding equity, stability and sustainability.

The Victorian modification involves removing the effect of 44 secondary diagnosis codes for the purpose of grouping to Vic-DRG8.0

These codes have been identified through consultation with the Department’s Chief Medical Officer to be ‘not clinically relevant’ for the purpose of determining DRG funding outcomes.
Update to coding standards in 2017-18

*Tenth edition ICD-10-AM/ACHI/ACS*

From 1 July 2017 updates to coding standards will include:

- Tightening of coding standards
- Development of clinical coder ethics
- Regulation of clinician query process
As part of the addendum to the National Health Reform Agreement, Victoria has committed to providing an attestation to the Independent Hospital Pricing Authority on the quality of Victorian hospital data. As such, the department are required to ensure that health services understand their obligations in regard to clinical coding.

Guidance of clinical coder ethics was developed in 2016-17

https://www.accd.net.au/Ethics.aspx

Health services are reminded that a clinical coder should not:

• Code diagnoses/interventions without supporting documentation for the purpose of ‘maximising’ hospital reimbursement.

• Omit diagnoses/interventions for the purpose(s) of minimising financial loss, or legal liability.

• Use the interdisciplinary engagement process inappropriately. This includes:
  – prompt or use leading questions for purposes of ‘maximising’ reimbursement
  – use details for potential financial gain as part of a clinician query process
  – seek additional documentation for conditions not already apparent in the existing clinical documentation
## WIES24
### Summary of model updates

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<th>Model updates</th>
<th>Outcome</th>
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<td><strong>Refreshing WIES model</strong>&lt;br&gt;• 2015-16 cost data&lt;br&gt;• DRG boundaries refreshed using latest 5 years of available data&lt;br&gt;• Medical indemnity&lt;br&gt;• Normative pricing for hips and knees&lt;br&gt;• Lions Eye Donation Services</td>
<td>Minimal changes</td>
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<td><strong>Adjustment to Thalassaemia copayment</strong>&lt;br&gt;• Aligning with reported costs</td>
<td>Reduction of thalassaemia copayment from 0.2648 WIES to 0.1089 WIES&lt;br&gt;• Closer to 100 per cent cost recovery</td>
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<td><strong>Victorian DRG for Endovascular Clot Retrieval (ECR) B02Y</strong></td>
<td>Cost recovery for B02Y is at 89%&lt;br&gt;• Cost recovery for DRGs that ECR is currently grouped to will reduce from 94% to 85% (B02A, B02B, B02C)</td>
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<td><strong>Adjustment for 10th edition ICD-10-AM coding</strong></td>
<td>Small movement of cases between adjacent DRGs&lt;br&gt;• Estimated impact mostly on DRG grouping of episodes with a principal diagnosis code for abnormal findings on diagnostic imaging of uterus (Creation of R93.51 under 10th Edition)</td>
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<td><strong>Short Stay Observation Units (SSOU) weights for designated DRGs</strong></td>
<td>Cost recovery for SSOU decreased from 127% to 100%&lt;br&gt;More equitable funding for same day and one day cases for designated DRGs</td>
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<td><strong>Victorian modification to DRG8.0 (Vic-DRG8.0)</strong>&lt;br&gt;• Removing influence of 44 secondary diagnosis codes that are considered to be ‘not clinically relevant’ for funding purposes</td>
<td>Moderation of WIES inflation with introduction of complexity model for AR-DRG8.0 that was introduced in 2016-17 nationally and in Victoria.</td>
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