

DATA TRENDS



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will CMS's adoption of severity-adjusted DRGs promote upcoding?

The analysis for this article was provided by Ingenix. For more information, send an e-mail to inform@ingenix.com.

Since 1983, the Centers for Medicare and Medicaid Services has paid hospitals using a prospective payment system based on a case mix classification using diagnosis-related groups. The current DRG system has evolved through a series of annual revisions, but CMS has put U.S. acute care hospitals on notice that, this year, it intends to undertake a potentially wholesale revision of the DRG system for FY08 by adopting "severity-adjusted DRGs." CMS is now evaluating its options with regard to severity-adjusted DRGs and is expected to announce its decision in April, when it releases the FY08 final rule for the hospital inpatient PPS.

Although the precise characteristics of the severity-adjusted DRGs are not yet known, all options that CMS is considering have a common structure. Each option groups cases into an initial set of categories based primarily upon the principal diagnosis and the presence or absence of an operating room procedure. These categories are then subdivided based on the presence or absence of complications and comorbidities, in what is referred to as a CC split.

Unlike the current CMS DRG system, severity-adjusted DRGs typically distinguish among CCs based on their clinical significance. For example,

cases with major CCs might be distinguished from those with moderate CCs. Also, the CC structure is likely to be applied uniformly across all cases, which will raise the importance of secondary diagnoses in determining how much Medicare pays a hospital for any particular case. There is some concern that hospitals will respond to new incentives by increasing the frequency with which they code CCs among secondary diagnoses.

A review of the percentage of Medicare discharges in 2005 that contained one or more CCs among secondary diagnoses discloses that hospitals already code CCs on most of their bills. This finding suggests that presence of a CC on a bill may not be as influenced by financial incentives as some would suggest. Although the proportion of cases containing a CC among medical DRGs that do not currently have a CC split is slightly smaller than the proportion among medical DRGs with a CC split (77.3 percent versus 84.0 percent), the pattern is actually reversed among surgical cases. That is, the proportion of cases with a CC is actually higher among surgical cases where there is no current CC split—and no financial incentive to code CCs—than among surgical cases where there is such an incentive (73.0 percent versus 71.9 percent). Indeed, data suggest that hospitals have been coding CCs at high rates for years, although there does appear to be a slight upward drift over time.

These findings suggest that the potential for upcoding in response to the introduction of severity-adjusted DRGs may be relatively small. They also suggest that coding practices may be less influenced by financial incentives than by coding guidelines and professional standards that are designed to ensure that hospitals record as much clinically significant information as possible on their bills. ●

TRENDS IN CC CODING RATES BY TYPE OF CASE AND PRESENCE OF A CC SPLIT IN CURRENT CMS DRG STRUCTURE, 2001-05

	2001	2002	2003	2004	2005
Medical cases w/ CC split	81.8%	82.6%	83.0%	83.5%	84.0%
Medical cases w/o CC split	72.0%	73.1%	74.9%	76.1%	77.3%
Surgical cases w/ CC split	71.7%	72.4%	73.4%	72.0%	71.9%
Surgical cases w/o CC split	71.8%	72.0%	72.3%	73.0%	73.0%

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