



# IMA INSIGHTS

## HAVE YOU PREPARED FOR MEDICARE'S SEVERITY DRGs?

To our Healthcare Clients and Friends:

In this edition of *IMA Insights*, we will discuss Medicare's recently published proposed rule intended to significantly change the current reimbursement landscape for Inpatient Prospective Payment System (IPPS) hospitals. The current diagnosis-related groups (DRG) reimbursement system (now referred to by CMS as CMS-DRGs) methodology has seen few changes since its inception in 1983. However, in part due to recommendations made by the Medicare Payment Advisory Commission (MedPAC), CMS is now proposing significant changes, which could be effective as early as October 1, 2007. This edition of *IMA Insights* will focus on the reimbursement aspects of the proposed MS-DRG system, while future editions will focus on the numerous operational implications.

### BACKGROUND

Rather than purchasing a severity adjusted DRG methodology and system from an independent vendor, CMS is proposing to adopt their own system. While it will be based on the current CMS-DRG system, the proposed system will be much more detailed to "in theory" better recognize the severity of a patient's condition. MS-DRGs are expected to allow for CMS payment to be more closely related to a patient's medical condition, recognizing case complexity and hospital resource (cost) use more accurately.

The proposed MS-DRG system will convert the current 538 active CMS-DRGs into 745 MS-DRGs. Many of the current CMS-DRGs convert into two or three different MS-DRGs. Reimbursement under this system will be partially differentiated by a patient's complications and comorbidities, within the following classifications:

<b>MCC:</b>	Major Complications or Comorbidities
<b>CC:</b>	Complications or Comorbidities
<b>Non-CC:</b>	No Complications or Comorbidities

The highest reimbursed cases would be those falling into the MCC category, and the lowest would be those falling into the Non-CC category. In addition to basing the MS-DRGs on the current CMS-DRG system, CMS has built this proposed system as follows:

- Consolidation of Existing CMS-DRGs into "Base" MS-DRGs.
- Categorization of Each Diagnosis as MCC, CC or non-CC.
- Division of each "Base" DRG into subclasses based on CCs.
- Within each Proposed "Base" MS-DRG, Some Cases Paid More, Some Paid Less.
- Budget Neutrality Leads to "Winners" and "Losers".
- "Behavior" Adjustment to Offset Anticipated Improvements in Provider Coding/Documentation.

In creating this proposed system, CMS appears to have the following main goals in mind:

- Better recognize the severity of a patient's medical condition.
- Reduce operating margins for current high-profit service lines.
- Lessen current incentives for physician-owned specialty hospitals.
- Align hospitals with clinical rather than financial incentives, consistent with community need for services.

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### KEY ISSUES AND CONSIDERATIONS

The proposed MS-DRG system, if implemented, will have significant financial and operational implications for hospital providers. This will result in a greater challenge for hospitals to retain financial viability for certain service lines that are currently very profitable. Hospitals will be faced with several issues, including the following:

#### *Enhanced Medical Documentation Requirements*

In order to receive appropriate MS-DRG reimbursement, all complications and comorbidities must be documented in the patient's medical chart. Under CMS-DRGs, this has always been "important", but the proposed MS-DRG system will differentiate payment even more heavily on such factors. Physician education relative to medical documentation is extremely important and incentives may need to be established to encourage physicians to improve such processes.

#### *Monitoring of Medicare Case Mix Index (CMI)*

Proper physician medical documentation and knowledgeable coding expertise will help providers attain their optimal CMI, meaning they will receive the Medicare reimbursement they are entitled to. Once Medicare claims are paid under the proposed MS-DRG system, a reasonableness analysis should be conducted relative to the conversion of CMS-DRGs to the corresponding MS-DRGs. To the extent that the conversion results are not reasonable, further analysis relating to medical documentation will be necessary.

#### *Coding Compliance*

Since the proposed payment methodology provides for more detailed classifications, there will be a significant difference in reimbursement if a hospital does not have a proper level of coding expertise. Obviously, additional focused training will be required as well as more concurrent reviews prior to billing.

#### *Determining Net Reimbursement Impact*

Since this proposed MS-DRG methodology change is so significant, it could result in a large difference in the amount of Medicare reimbursement due hospitals. CMS appears to expect large urban hospitals to receive higher reimbursement under the proposed system. CMS has noted that specialty, small urban, and rural hospitals could all see less reimbursement than they currently receive.

### INSIGHTS

In order to pinpoint the financial impact of the proposed MS-DRG system associated with specific clinical services, IMA Consulting compared the relative weights under the current CMS-DRGs to what they convert into under the proposed MS-DRGs. The following list highlights the MS-DRGs with the five most favorable and five most unfavorable conversion results. This information can assist providers relative to strategic initiatives to modify future patient volumes in those areas.

*While there are expected to be "winners" from the proposed MS-DRG system, they can only attain those higher reimbursement levels once they get up to speed on medical documentation issues. In the short-term, those same hospitals will most likely see reimbursement reductions.*

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### 5 Most Favorable

MS-DRG 001 (weight increase of 5.6)  
 MS-DRG 326 (weight increase of 4.6)  
 MS-DRG 453 (weight increase of 3.9)  
 MS-DRG 870 (weight increase of 3.9)  
 MS-DRG 329 (weight increase of 3.7)

### 5 Most Unfavorable

MS-DRG 002 (weight decrease of 7.2)  
 MS-DRG 006 (weight decrease of 4.5)  
 MS-DRG 328 (weight decrease of 3.7)  
 MS-DRG 855 (weight decrease of 3.0)  
 MS-DRG 022 (weight decrease of 2.9)

Additionally, the following chart outlines the largest shifts in relative weights between CMS-DRGs and MS-DRGs, which were computed as the relationship between the relative weight under the current CMS-DRG system and both the highest and lowest relative weights for the corresponding proposed MS-DRGs. The reimbursement estimates shown below are based on FFY 2007 national adjusted operating standardized amounts with the full update and the FFY 2007 capital standard federal payment rate, for the Philadelphia, Pennsylvania CBSA. These estimates do not include any hospital-specific add-ons such as Disproportionate Share Hospital (DSH) or Indirect Medical Education (IME) payments.

	<b>MS-DRG Title</b>	<b>Reimbursement Estimate</b>	<b>% Change</b>
1	<b>Heart Transplant or Implant of Heart Assist System</b> CMS-DRG 103 (weight of 18.8653) MS-DRG 001 w MCC (weight of 24.4652) MS-DRG 002 w/o MCC (weight of 11.6444)	\$107,532 \$139,452 \$66,373	30% (38%)
2	<b>Liver Transplant</b> CMS-DRG 480 (weight of 9.4096) MS-DRG 005 w MCC (weight of 10.7737) MS-DRG 006 w/o MCC (weight of 4.8801)	\$53,635 \$61,410 \$27,817	14% (48%)
3	<b>Combined Anterior/Posterior Spinal Fusion</b> CMS-DRG 496 (weight of 6.3782) MS-DRG 453 w MCC (weight of 10.2692) MS-DRG 454 w CC (weight of 6.6576) MS-DRG w/o CC/MCC (weight of 4.9313)	\$36,356 \$58,534 \$37,948 \$28,108	61% 4% (23%)
4	<b>Cardiac Valve &amp; Other Major Cardiothoracic Procedure w/ Cardiac Cath</b> CMS-DRG 104 (weight of 8.2903) MS-DRG 216 w MCC (weight of 10.3150) MS-DRG 217 w CC (weight of 6.9289) MS-DRG 218 w/o CC/MCC (weight of 5.4894)	\$47,255 \$58,796 \$39,495 \$31,290	24% (16%) (34%)
5	<b>Chemo w Acute Leukemia as SDX or w High Dose Chemo Agent</b> CMS-DRG 492 (weight of 3.4892) MS-DRG 837 w MCC (weight of 5.8967) MS-DRG 838 w CC (weight of 2.4571) MS-DRG 839 w/o CC/MCC (weight of 1.2593)	\$19,888 \$33,611 \$14,005 \$7,178	69% (30%) (64%)

The above figures indicate a percent change disparity ranging from +69% to -64%. That wide disparity helps explain why medical documentation and coding will be even more critical under the proposed MS-DRG system. For example, in the fourth highest disparity item listed above, "Cardiac Valve & Other Major Cardiothoracic Procedure w/ Cardiac Cath", the current CMS-DRG 104 has a relative weight of 8.2903. Under the proposed MS-DRG system, if medical documentation and coding accurately supports a "w MCC" classification of MS-DRG 216, the provider will receive a higher relative weight of 10.3150. Therefore, they will receive 24% greater reimbursement under MS-DRGs. Conversely, if the provider does not maintain proper medical documentation and coding, they will receive less Medicare reimbursement under



**IMA  
Consulting**

Three Christy Drive  
Chadds Ford, PA 19317

Phone: 484.840.1984  
Fax: 484.840.0124

Toll Free: 866.840.0151



*Helping organizations implement change  
cost effectively.*

**William R. Weeks,  
Partner**

**Robert D. Sutton,  
Partner**

**Anthony J. Scarcelli, Jr.,  
Partner**

**Mary Ann Holt,  
Partner**

**Kimberly Hollingsworth,  
Partner**

**Robert J. De Luca,  
Partner**

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the proposed MS-DRG system than they would have under the CMS-DRG system.

It is also important to note that the more Medicare makes up of a particular service line’s payer mix, the greater the MS-DRG system’s potential financial impact. Therefore, service lines associated mostly with the elderly population (such as cardiovascular) have the most financial risk and opportunity.

Once the Final rule is issued, providers will have very little time to prepare for these changes. It is possible that they will be given as little as 60 days notice. While there are expected to be “winners” from the proposed MS-DRG system, they can only attain those higher reimbursement levels once they get up to speed on medical documentation issues. In the short-term, those same hospitals will most likely see reimbursement reductions. It is important that hospitals strategically analyze their clinical service lines to determine which services they want to expand or diminish, given the financial changes under the MS-DRG system.

**CONCLUSION**

Medicare’s proposed severity-adjusted MS-DRG system is more detailed, requires significantly enhanced medical documentation processes and, if administered correctly by hospitals, will improve payment accuracy. Given how the proposed system is built, and its various complexities, physician medical documentation training and coding are critical to a hospital’s financial performance. Estimating the Medicare reimbursement impact of the proposed MS-DRG system is also very important, as it could result in a significant bottom line change.

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We are pleased to have had the opportunity to provide this information to you. If you have any questions or need assistance with preparing for MS-DRGs, please do not hesitate to contact either Scott Kazanjian at (267) 253-5264 or myself at (484) 354-7595.

Yours very truly,

*Bob*

Robert J. De Luca, Partner  
IMA Consulting

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cjachetti@ima-consulting.com**