



MS-DRGs: SEVERITY OF ILLNESS MATTERS

To our Healthcare Clients and Friends:

The July 2007 edition of *IMA Insights* discussed the Centers for Medicare and Medicaid Services' (CMS) recently published proposed rule intended to change the current reimbursement landscape significantly for Inpatient Prospective Payment System (IPPS) hospitals. While the July Insights discussed the background and reimbursement implications of this proposed change, this edition addresses some key operational considerations.

In updating the hospital IPPS for fiscal year 2008, CMS proposes to adopt a severity-adjusted diagnosis-related group (DRG) system, designated Medicare-Severity Diagnosis-Related Groups (MS-DRGs). The proposal creates 745 new DRGs to replace the current 538 DRGs. According to CMS, the reforms provide measured steps to improve the accuracy of Medicare's payment for inpatient stays by recognizing severity of illness and resource usage based on case intricacy. CMS has proposed implementation as early as October 1, 2007.

CMS's proposed changes in methodology represent a shift in not only the mechanisms for payment, but in the underlying philosophy, as well. The current CMS-DRGs focus on complexity, defined as the relative volume and types of diagnostic, therapeutic, and bed services required for the treatment of a particular illness. The proposed MS-DRGs will incorporate severity of illness as a major factor. Severity of illness represents the extent of physiologic decompensation or organ system loss of function identifying multi-system significant disease. The level of care may require increased hospital resource use because of a need for such services as intensive monitoring, expensive and technically complex services, or extensive care requiring a greater number of care providers. Further, additional resources may be required for educational and coding requirements. The end result is an additional strain on limited resources and increased costs per unit of service.

Preliminary results demonstrate that under the severity-adjusted system, urban hospitals have a higher average CMI than under the CMS-DRGs, and rural hospitals have a lower CMI. This impact occurs because patients treated in urban hospitals are generally more severely ill than patients in rural hospitals and the CMS-DRGs are not currently recognizing the full extent of these differences.

KEY ISSUES AND CHALLENGES

What if your hospital's CMI changes?

Changes in patient mix and medical practice signal real changes in underlying resource utilization and cost of treatment. Three factors determine these changes.

- a) Admitting and treating a more resource-intensive patient mix (due, for example, to technical changes that allow treatment of previously untreatable conditions or different patient population, e.g., an aging population, or additions to the medical staff).
- b) Providing services (such as higher cost surgical treatments, medical devices, and imaging services) on an inpatient basis that were not provided previously or furnished in an outpatient setting.
- c) Changes in documentation (more complete medical records) and coding practice (more accurate and complete coding of the information contained in the medical record).

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What do the changes mean?

CMS-1533-P identifies three different levels of complication and co-morbidity severity into which diagnosis codes subdivide. The proposed three levels are Major Complications or Comorbidities (MCC), Complications or Comorbidities (CC), and No Complications or Comorbidities (non-CC). Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs, which do not significantly affect severity of illness and resource use. The proposed rule lists 1,389 secondary diagnoses designated as MCCs and 2,913 secondary diagnoses designated as CCs.

MS-DRGs have both CCs and MCCs so hospitals can convey to Medicare when they treat patients with secondary diagnoses that increase the resources required and, thus, the associated costs of care. MCCs are reserved for the more severely ill patients.

The revised CC list includes significant acute diseases, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases, and chronic diseases associated with extensive debility. This revised CC list requires a secondary diagnosis to have a consistently greater impact on hospital resources.

The table that follows displays a comparison of the current and revised complications and comorbidity lists. Note that the average charges for patients with one or more complication and comorbidity increases more significantly than those for patients without complications and comorbidities. However, also note that the codes designated as complications or comorbidities decreases significantly. This, again, underscores the need for more complete and accurate documentation and coding.

Comparison of Current CC List and Revised CC List (CMS-1533-P)

	Current CC List	Revised CC List
Codes designated as a CC	3,326	2,583
Percent of patients with one or more CCs (FY 2006 MedPar data)	77.66	40.34
Percent of patients with no CC	22.34	59.66
Average charge of patients with one or more CCs	\$24,538	\$31,451
Average charge of patients with no CCs	\$14,795	\$16,215

The proposed MS-DRGs will incorporate severity of illness as a major factor.

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How are chronic diseases assigned?

A significant acute manifestation of a chronic disease must be present and coded for the patient to be assigned a CC. CMS made exceptions for diagnosis codes that indicate a chronic disease in which the underlying illness has reached an advanced stage or is associated with systemic physiologic decompensation and debility.

The presence of such advanced chronic diseases, even in the absence of a separately coded acute manifestation, significantly adds to the treatment complexity of the patient. Thus, the presence of the advanced chronic disease inherently makes the reason for admission more difficult to treat. For example, quadriplegia (codes 344.00 through 344.09) requires extensive care with a substantial increase in nursing services and more intensive monitoring. Again, assuring that medical record documentation reflects these conditions assists in helping receive proper reimbursement for services provided.

INSIGHTS

So how can your hospital identify the keys to success?

Your top priority is to assure accurate reimbursement by getting credit for patients' severity of illness. Several actions can help accomplish this, including education, documentation, and coding. History tells us that the better our physicians and coders understand these new complexities and how it impacts their day-to-day tasks, hospitals will be better positioned to ensure that they are receiving all of the reimbursement to which they are entitled. Unfortunately, time may not be on our side and the operational implications are far reaching. The time to begin the education process is now.

First, conduct information and education sessions so all those involved in clinical documentation, coding, and billing functions to assure that they understand the implications of the proposed changes. While this education can focus on the financial repercussion of the proposed changes, incorporate the changes you anticipate in work processes to accommodate the proposal.

Second, one cannot overstate the importance of a documentation improvement program. Physician documentation plays a crucial role in obtaining proper reimbursement. It is no longer sufficient for physicians to state a diagnosis – clarification is a must. Clarifying documentation (for example diabetic complications, degree of malnutrition, type of anemia, source of GI bleed, type of pneumonia, ventilator time, etc.) will mean the difference between levels of severity and reimbursement. As coders are not able to interpret a case, the increased specificity, accuracy, and completeness of data are imperative for coding optimization. The documentation training should include all inpatient healthcare providers who denote patients' conditions in the records, or make decisions based on clinical documentation.

Third, case managers have the opportunity to collaborate with physicians on identifying severity-adjusted diagnoses in their documentation. The case manager's ability to view the patient's entire clinical presentation enhances the physician's range of documentation to include richer clinical detail. In addition, case managers may assign inpatient admission and continued stay approvals using evidenced-based guidelines for decreased denials and appeals. They can incorporate prompt, thorough, and comprehensive discharge planning and follow-up, which will influence patient readmissions.



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Last but certainly not least, increased coder training is essential. Changes in coding patterns or behaviors could improve payments within the severity-adjusted DRG system. Increases in CMI after adopting the system could be the result of improved coding rather than increases in actual patient severity. However, the changes may lead to decreased coder productivity as more time is needed per record.

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 Sandy Moline at 484-832-1895 or myself at 610-659-9530.

Yours very truly,

Mary Ann Holt, RN, MSN
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Read CMS-1533-P at:
www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp#TopOfPage.

IMA Consulting has moved its corporate office.

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