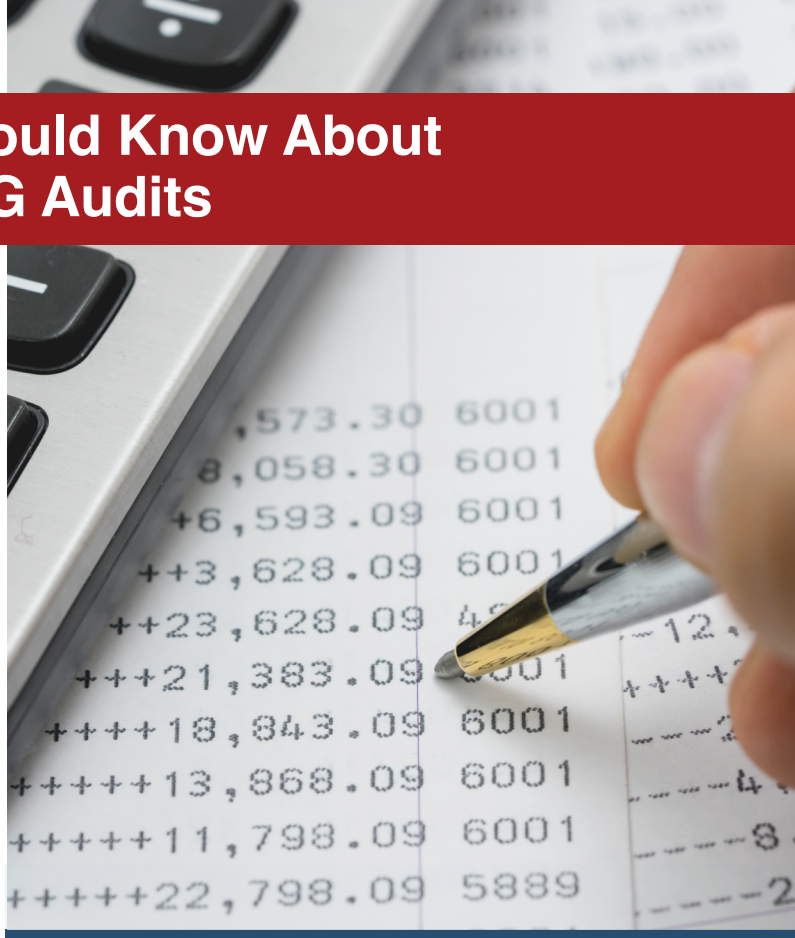
COUNCIL FOR MEDICARE INTEGRITY

What You Should Know About Medicare DRG Audits



What is a DRG?

A Diagnosis-Related Group (DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Factors used to determine the DRG payment amount include the diagnosis involved as well as the hospital resources used to treat the condition. Hospitals are paid a fixed rate for inpatient services corresponding to the DRG group assigned to a given patient.

CMS has identified DRG coding issues as an area with a high number of improper payments, generally more than a 20% billing error rate. Under the new contracts, Recovery Auditors have already been given approval by CMS to audit all DRG codes for billing errors.

How Are DRG Audits Completed?

DRG audits are reviews to look at how a patient presented, how they were diagnosed and treated and and then how the claim was coded. Coders conduct DRG reviews using CMS rules and guidelines. No medical necessity determinations are made. DRG reviews simply validate if the diagnosis code billed matches the care a patient received to ensure the correct code has been billed.

For Example: A patient might be admitted for dizziness with low blood pressure. The patient was also found to have severe dehydration and acute renal failure. The facility initially submitted the claim with a principal diagnosis of low blood pressure. After review a coder determined that this was not the condition that was the primary focus of care and replaced the principal diagnosis with a principal diagnosis of acute renal failure.

Why are DRG audits so simple?

DRG audits are very straightforward reviews to ensure that the services provided match the diagnosis code billed. There is never an outright denial of the claim. The majority of DRG coding errors are due to up-coding. If a DRG code is found to be incorrect, it is corrected by the auditor, the payment is recalculated and the provider receives a letter requesting the difference be returned to the Medicare Trust Fund. As a result, DRG audits have a very low rate of appeal.

Top 10 Part A DRG Service Types with the Highest Billing Errors (CERT, 2015)

DRG Code	Billing Error Rate
Chest Pain	45.9%
Transient Ischemia	44.9%
Back & Neck Proc. Exc. Spinal Fusion	34.6%
Syncope & Collapse	28.0%
Cardiac Defibrillator Implant W/O Cardiac Cath.	25.6%
Medical Back Problems	21.2%
Esophagitis, Gastroent. & Misc. Digest Disorder	20.4%
Degenerative Nervous System Disorder	19.8%
Kidney & Urinary Tract Infections	19.1%
Misc. Disorders of Nutrition/Metabolism/Fluids	17.2%