EvidenceCare

What are DRGs?

CareGauge

Diagnosis-Related Groups (DRGs)

Categorize patients based on their medical conditions and the associated treatment costs. DRGs are defined based on a patient's primary and secondary (comorbid) diagnoses, surgical procedures, age and gender.

CMS and other payers use DRGs to determine how much the hospital will be reimbursed for that patient's episode of care. The 70,000+ ICD-10 codes are grouped into less than 1,000 DRGs.

Within the DRG system, there are two important distinctions that have a significant impact on DRG assignment, reimbursement, and the overall classification of patients' medical conditions.

1. Complication or Comorbidity (CC)
- CCs are additional medical conditions or complications that a patient may have alongside their primary diagnosis. These conditions can affect the complexity and cost of treatment
- CCs reflect the added resources and care required to address the patient's underlying condition along with the secondary condition or complication
- Example: Pneumonia with Acute COPD Exacerbation

2. Major Complication or Comorbidity (MCC)
- MCCs are even more severe or complex secondary conditions or complications that significantly impact patient care and treatment costs
- The presence of an MCC typically results in a higher-weighted DRG than a CC
- Example: Stroke with Respiratory Failure

The Working DRG is a key input to drive utilization comparisons in CareGauge, but what is a Working DRG?

When a patient is admitted, the hospital's case management and documentation team will collaborate to determine the DRG for that patient. Software is often used to make an automated determination, which is called the Working DRG, based on information documented in the patient's chart. Thereafter, the CDI team will review and update that DRG, as appropriate. The Final DRG is available once coding is complete post discharge.

CareGauge ingests the Working DRG, along with any updates, which serve as a critical input for evaluating a patient's care utilization in comparison to other patients with the same DRG within the organization's baseline period. This allows for tailored comparisons specific to the organization's case mix.

DRG Code	Description	Category / Subcategory	GMLOS	Estimated Cost*
195	Simple Pneumonia and Pleurisy	Pulmonology / Non-Surgical	2.5 Days	$3,000
194	Simple Pneumonia and Pleurisy with CC	Pulmonology / Non-Surgical	3.1 Days	$7,500
193	Simple Pneumonia and Pleurisy with MCC	Pulmonology / Non-Surgical	4.1 Days	$11,200

*Sample Data

What if the Working DRG appears to be wrong?

It's possible that the patient you are reviewing could be an outlier from a utilization perspective as compared to other patients with the same DRG in the baseline period. Nonetheless, here are some things to consider if you feel the Working DRG is accurate.

- Review the patient's problem list. Are the principal and any secondary diagnoses appropriate?
- Is there a complication or comorbidity (or major complication or comorbidity) present that isn't reflected in the DRG?