DRG - Diagnosis Related Groups

Source Articles:

United States:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html

https://www.ehealthmedicare.com/faq/what-are-diagnosis-related-groups/

To see MS-DRGs: https://www.cms.gov/ICD10Manual/version36-fullcode-cms/fullcode_cms/P0001.html

3M - APR-DRG: https://www.3m.com/3M/en_US/company-us/all-3m-products/~/3M-APR-DRG-Software/?N=5002385+3290603192&rt=rud

Australia:

AR-DRGs: https://www.aihw.gov.au/reports/hospitals/ar-drg-data-cubes/contents/data-cubes

https://www.ihpa.gov.au/admitted-acute-care/ar-drg-classification-system

https://www.accd.net.au/ArDrg.aspx

Glossary:

Acronym	Description	
APR-DRG	All Patient Refined Diagnosis Related Groups The 3M All Patient Refined DRG (APR DRG) Classification System uses standard patient discharge information to classify patients into clinically meaningful groups, then into four severity-of-illness (SOI) and four risk-of-mortality (ROM) subclasses within each 3M APR DRG code. The system aligns the care provided in the hospital with how it's paid and helps organizations better understand their populations' health across the care continuum.	3M
AR-DRG	*Australian Refined Diagnosis Related Groups (AR-DRGs)* is an Australian admitted patient classification system which provides a clinically meaningful way of relating the number and type of patients treated in a hospital (known as hospital casemix) to the resources required by the hospital. Each AR-DRG represents a class of patients with similar clinical conditions requiring similar hospital services.	See site above
CC	Complications or Comorbidities	
HCPCS-MS-DRG	The 21st Century Cures Act requires that by January 1, 2018, the Secretary develop an informational "HCPCS version" of at least 10 surgical MS-DRGs. Under the HCPCS version of the MS-DRGs developed for this requirement, to the extent feasible, the MS-DRG assignment for a given service furnished to an outpatient (billed using a HCPCS code) is as similar as possible to the MS-DRG assignment for that service if furnished to an inpatient (billed using an ICD-10-PCS code). The HCPCS-MS-DRG definitions manual and software developed under the requirements of section 15001 of the 21st Century Cures Act (Public Law 114–255).	Medicare Website
LTC-DRG	long-term care diagnosis-related groups The LTC-DRGs are the same DRGs used under the hospital inpatient prospective payment system (IPPS), but they have been weighted to reflect the resources required to treat the type of medically complex patients characteristic of LTCHs. Relative weights for the LTC-DRGs reflect resource utilization for each diagnosis and account for the variation in cost per discharge. Under the LTCH PPS, the LTC-DRG relative weights are updated annually for each Federal fiscal year (October 1st through September 30th) using the most recently available LTCH claims data. Beginning in FY 2008, we adopted the refined severity-adjusted DRGs that were also adopted under the IPPS, that is, the Medicare-Severity-LTC-DRGs (MS-LTC-DRGs), which continue to be weighted to account for the difference in resource use by LTCH patients.	Medicare Website
MCC	Major Complications or Comorbidities	
MCE	Medicare Code Editor	
MDC	Major Diagnostic Category	
MS-DRG	Medicare Severity — Diagnosis Related Group	

Background: (from Medicare website)

Section 1886(d) of the Social Security Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

Currently, cases are classified into Medicare Severity Diagnosis Related Groups (MS-DRGs) for payment under the IPPS based on the following information reported by the hospital:

- the principal diagnosis,
- up to 25 additional diagnoses, and
- up to 25 procedures performed during the stay.
- To group diagnoses into the proper DRG, CMS needs to capture a Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 Data Specifications Manual and the ICD-9-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional. (From: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html)

In a small number of MS-DRGs, classification is also based on:

- the age,
- sex, and
- discharge status of the patient.

Effective October 1, 2015, the diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS).