MS-DRG Journey: How One Hospital Joined together to Successfully Implement MS-DRGs

by Ginny Martin, RHIA, CCS

The Centers for Medicare and Medicaid Services (CMS) surprised the coding world last year when it changed its 22-year-old reimbursement system to the severity-adjusted MS-DRG system. HIM departments anticipated the system would have a significant impact on operations—increasing demands for accurate documentation, ensuring optimal data capture to compensate for the changes in coding and documentation, and educating staff on the use of the coded data.

How are hospitals and HIM departments faring now? For SwedishAmerican Hospital in Rockford, IL, thorough planning and collaboration among many departments made its MS-DRG implementation a successful one.

Educate, Educate, Educate

SwedishAmerican already had an established documentation improvement program in place when the MS-DRGs went into effect. This provided a strong foundation for meeting the new system's challenges. However, even with this infrastructure in place, coders, physicians, nursing staff, ancillary staff, and others who use coded data needed further education.

The organization began by learning about the new MS-DRG system, analyzing the documentation opportunities to support the illness severity of its patients. Staff attended numerous seminars, researched the changes with information provided on the CMS Web site, participated in free webinars provided by vendors, and took advantage of vendor offers to analyze the organization's data under the new MS-DRG system.

Coders and documentation specialists received specialized training by one of the organization's vendors, and the HIM department purchased software to analyze the coded data concurrently and prompt coders to look for secondary diagnoses that may affect severity of illness, risk of mortality, or a new MS-DRG. The supervisor provided staff with further site-specific education.

Prior to MS-DRG implementation, the data quality supervisor had established a coding education column in the organization's quarterly physician newsletter. Through these articles, SwedishAmerican began informing the medical staff of the upcoming changes, providing them with specific examples of what was needed in the way of documentation. The physicians were consistently asked to be more specific, and queries were used repeatedly. The new changes were also incorporated into the orientation for new physicians, residents, and other licensed independent practitioners.

The documentation specialists continually queried for more specific documentation and used their time on the floor to educate physicians one-on-one. Physicians were most receptive when they were shown how the documentation would affect the clinical picture of their patients and their personal physician scorecard.

When SwedishAmerican began its documentation improvement program, it decided to focus physician education on the documentation's effect on a patient's clinical picture, not reimbursement. All stakeholders, including physician leadership, HIM, and quality, supported this philosophy to motivate and change physician behavior.

In addition to providing education to physicians, the organization identified a need to provide tailored education to others in the organization who code or use coded data. It invited staff from nursing management, utilization review/discharge planning, quality resources, patient accounts, information systems, documentation specialists, and coding to a presentation of the new MS-DRG system. The presentation provided a detailed overview of MS-DRGs, including the major complications/comorbidities (MCCs) and complications/comorbidities (CCs), the new present on admission indicators, and hospital-acquired conditions. The presentation was customized to each audience.

Billing and Data Submission

On the data and reimbursement side, the HIM department worked very closely with patient accounts, quality resources, and information systems to ensure systems were in place to capture and report the data accurately for billing and reimbursement. An additional challenge was the work involved in modifying SwedishAmerican's information systems to ensure they could download the information to the many interfaced systems for data analysis and data submission.

Extensive testing was done within the organization's mainframe system to ensure it was accepting the new MS-DRGs and calculating the reimbursement correctly. Patient accounts reviewed the managed care and insurance contracts to determine which reimbursement system, CMS DRGs or MS-DRGs, was acceptable. Because of the language in the contracts, the organization was able to bill using MS-DRGs exclusively with the exception of Medicaid and Blue Cross/Blue Shield, which only accepted CMS DRG reimbursement.

The HIM and billing departments worked with information systems to prepare internal processes to group both MS-DRGs and CMS DRGs and submit both on the bill. This allowed decision support and cost and budget to calculate the impact on a month-by-month basis and compare both versions. Because of the extensive testing and planning, the organization was able to continue coding and billing with no delay.

Converting SwedishAmerican's data submission systems to outside agencies like the Maryland Hospital Association, the Joint Commission, and the Agency for Healthcare Research and Quality was an enormous effort. Many reports had to be manually rewritten to accommodate the changes. This took many months before all systems were operational and providing the organization with accurate data. Some of the external systems had bugs that needed to be corrected before the organization could fix its systems. However, SwedishAmerican was analyzing and submitting data within three months of the official change to MS-DRGs.

What's Happening Today?

The new systems have had a large impact on coder and documentation specialist productivity. Inpatient coder productivity decreased three to four charts per day per coder due to MS-DRGs, MCC and CC changes, and present on admission changes. SwedishAmerican has hired an additional full-time inpatient coder to help off-set the decrease in productivity. On a positive note, the organization is now in a better position to move forward with its plan to cross-train more coding staff.

The documentation specialists are reviewing approximately 20 percent fewer Medicare records but asking 30 percent more questions since the changes went into effect. These include questions for MCC and CC capture as well as clarification of diagnoses present on admission. The organization is evaluating the need for additional documentation improvement staff.

CMS predicted a decrease in the overall CC/MCC capture rate to 40 percent. SwedishAmerican's CC/MCC capture rate has dropped by a third; however, the organization's overall CC/MCC capture rate remains higher than the predicted 40 percent. Despite this, the organization's case-mix index has remained fairly constant, and the discharge not-final-billed showed only a slight increase. The organization attributes this to education, having its documentation improvement program infrastructure in place prior to the changes, and the intense planning and astute management of this project to make it a seamless conversion.

Looking to the Future

Leadership support and interdepartmental teamwork were critical to SwedishAmerican's success with its MS-DRG implementation. Staffing will continue to be monitored, and productivity standards will be adjusted as needed. Coders and documentation specialists will continue to query and educate physicians on documentation opportunities. It is imperative that the organization continue to educate to promote data quality and reflect the severity of illness of the patients it serves.

In the short term, SwedishAmerican will conduct an interim gap assessment to plan effectively for next year, when the coding industry will see further changes in coding and documentation requirements. The organization will also evaluate the hospital-acquired conditions that may effect reimbursement and continue to evaluate data quality for other quality initiatives and hospital and physician report cards.

SwedishAmerican's team approach has enabled it to react quickly and effectively to the constantly evolving reimbursement landscape. It is important that all organizations evaluate and monitor processes when changes occur and adjust expectations based on the results.

Resources

AHIMA. "Analysis of Final Rule for FY 2008 Revisions to the Medicare Hospital Inpatient Prospective Payment System." Available online at www.ahima.org/dc/documents/MicrosoftWord-IP-PPSanalysis-FY08_000.pdf.

"Medicare: Hospital Inpatient Prospective Payment Systems and 2008 FY Rates." *Federal Register* 72, no. 162 (August 22, 2007). Available online at www.access.gpo.gov/su_docs/fedreg/a070822c.html.

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