

MS-DRG Grouping

Find-A-Code Tutorials

Version 1, Oct 2011

This is an instruction guide to DRG grouping within the Find-A-Code system.

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Introduction

Diagnosis-related group (DRG) is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use. They have been used in the United States since 1983. There is more than one DRG system being used in the United States, but only the MS-DRG (CMS-DRG) system is used by Medicare. FindACode uses the MS-DRG system as it relates to the Medicare Inpatient Prospective Payment System (IPPS).

DRG *Grouping* is the method used to assign a DRG based on the diagnoses made and procedures performed for a particular patient's case. It takes into account the principal diagnosis, any secondary diagnoses that may act as complications, as well as the procedures (either surgical or non-surgical). In some cases gender and discharge status are also required to group a case into a DRG. Only one DRG is assigned for each case, so Grouping finds all applicable DRGs and assigns the highest severity DRG that applies.

What you'll need

In order to group a case into a DRG within the Find-A-Code system, you'll need:

- The principal diagnosis
- Any secondary diagnoses
- All procedures performed
- Patient gender (not always needed)
- Patient discharge status (not always needed)

How it works

The main flow of DRG Grouping is as follows:

1. Find the Major Diagnostic Category (MDC) for the case
 - (a) Check if the case procedure requirements to be assigned to the PRE MDC
 - (b) If not, find the MDC based on the principal diagnosis – with top priority going first to MDCs 24 (Multiple Significant Trauma), then 25 (HIV)
2. Find out whether or not any Operating Room (OR) procedures were performed.
3. Find the applicable DRG from the MDC
 - (a) If OR procedures were performed,
 - i. go down the list of Surgical DRGs in the MDC and find which DRGs apply.
 - (b) If OR procedures were not performed
 - i. go down the list of Medical DRGs in the MDC and find which DRGs apply.
 - (c) If the DRGs make a distinction based on complications, check the secondary diagnoses to see if any qualify as Complications/Comorbidities (CC) or Major Complications/Comorbidities (MCC)
 - (d) If a secondary diagnosis *does* qualify as a CC or MCC, check the exclusion lists to ensure it is not excluded by the principal diagnosis.

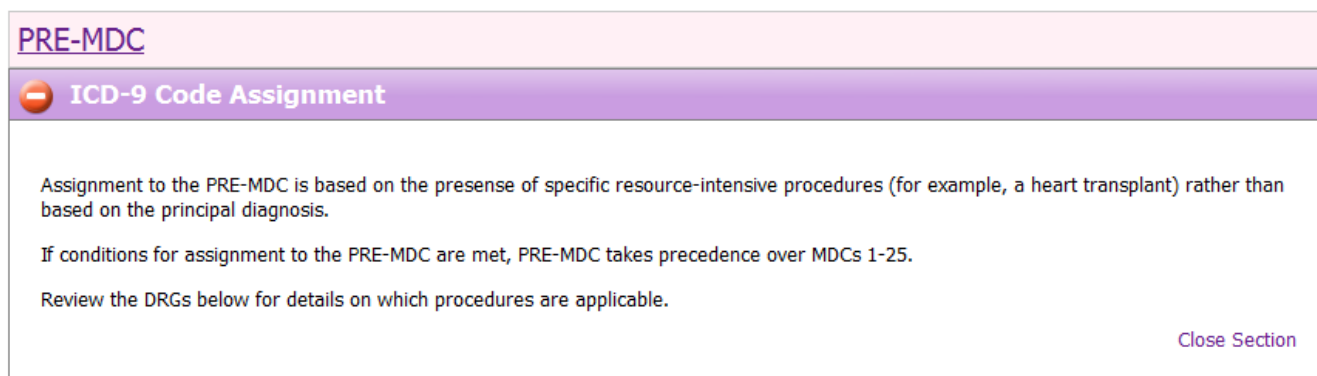
Step-by-Step Walk-through

Step 1: Find the Major Diagnostic Category (MDC) for the case

This used to be pretty straight-forward, and you could look up the right MDC just according to the Principal Diagnosis – but then some exceptions were added that made it a little more round-about.

PRE-MDC – Resource-Intensive Procedures

Several resource-intensive procedures, such as transplant of the heart, liver, lung, pancreas, bone marrow, as well as tracheostomies, will categorize the case into the PRE-MDC, regardless of the principal/secondary diagnoses. If the case did qualify for PRE-MDC, move on to step 2.

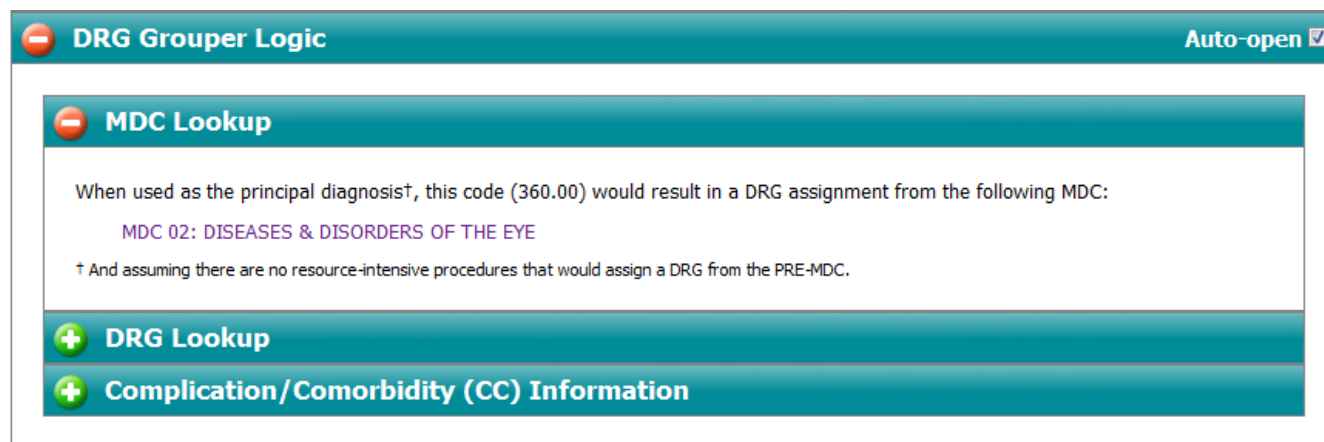


The screenshot shows a software interface for PRE-MDC assignment. At the top, there is a purple header bar with the text "PRE-MDC" in white. Below this is a darker purple bar with a red minus icon and the text "ICD-9 Code Assignment". The main content area is white and contains three paragraphs of text: "Assignment to the PRE-MDC is based on the presence of specific resource-intensive procedures (for example, a heart transplant) rather than based on the principal diagnosis.", "If conditions for assignment to the PRE-MDC are met, PRE-MDC takes precedence over MDCs 1-25.", and "Review the DRGs below for details on which procedures are applicable." In the bottom right corner of the white area, there is a link that says "Close Section".

Illustration 1: PRE-MDC ICD-9 Code assignment

Normal MDC Lookup

If the procedures didn't qualify for a DRG from the PRE-MDC, then it will be assigned one from a numbered DRG, 1 through 25. Go to the code page for your principal diagnosis, open up the "DRG Grouper Logic" section, and pop open "MDC Lookup". It will list at least one MDC here, although occasionally more. If you only see one, congrats! you've found your MDC – move on to Step 2. If there are multiple, you'll need to check to see which you qualify for.



The screenshot shows a software interface for DRG Grouper Logic. At the top, there is a teal header bar with a red minus icon, the text "DRG Grouper Logic", and an "Auto-open" checkbox with a checkmark. Below this is a white content area with a teal bar at the top containing a red minus icon and the text "MDC Lookup". The main content area is white and contains a paragraph: "When used as the principal diagnosis†, this code (360.00) would result in a DRG assignment from the following MDC:" followed by "MDC 02: DISEASES & DISORDERS OF THE EYE" in purple text. Below this is a footnote: "† And assuming there are no resource-intensive procedures that would assign a DRG from the PRE-MDC." At the bottom of the white area, there are two teal bars with green plus icons and the text "DRG Lookup" and "Complication/Comorbidity (CC) Information".

Illustration 2: "DRG Grouper Logic" section for code 360.00

Special Case MDCs

Assignment to the following DRGs is based on more than the principal diagnosis.

MDC 24 – Multiple Significant Trauma (MST)

Assignment to MDC 24 is based on a principal diagnosis of significant trauma, and at least two significant trauma diagnoses from *different* site categories (Chest, abdomen, kidney, urinary system, pelvis/spine, upper limb, lower limb, head). You can check <http://www.findacode.com/code-set.php?set=DRG&mdc=24> to see lists of the diagnoses that qualify as significant trauma in each area, or you can also look in the “MDC Lookup” section under “DRG Grouper Logic” on an ICD9 code page to see if one of your diagnoses qualifies as a significant trauma. Remember though that you need *two* significant traumas from *different* body site categories in order to qualify for MDC 24.

MDC 24: MULTIPLE SIGNIFICANT TRAUMA

ICD-9 Code Assignment

Assignment to MDC 24 is based on a principal diagnosis of significant trauma and at least two significant trauma diagnoses of different body site categories.

If conditions for assignment to MDC 24 are met, MDC 24 takes precedence over MDCs 1-23 and 25.

- + SIGNIFICANT CHEST TRAUMA
- + SIGNIFICANT ABDOMINAL TRAUMA
- + SIGNIFICANT TRAUMA OF KIDNEY
- + SIGNIFICANT TRAUMA OF THE URINARY SYSTEM
- + SIGNIFICANT TRAUMA OF PELVIS OR SPINE
- + SIGNIFICANT TRAUMA OF THE UPPER LIMB
- + SIGNIFICANT TRAUMA OF THE LOWER LIMB
- + SIGNIFICANT HEAD TRAUMA

Close Section

III

ustration 3: MDC 24 (MST) ICD-9 Code Assignment

MDC 25 – Human Immunodeficiency Virus Infections (HIV)

Assignment to MDC 25 is based on either a principal diagnosis of HIV Infection or a principle diagnosis of a significant HIV-related condition and a secondary diagnosis of HIV Infection. This one should be pretty easy to answer – if HIV was present, check the “ICD9 Code Assignment” section at <http://www.findacode.com/code-set.php?set=DRG&mdc=25> to see if the case qualifies for MDC 25. If so, move on to Step 2.

MDC 25: HUMAN IMMUNODEFICIENCY VIRUS INFECTIONS

ICD-9 Code Assignment

Assignment to MDC 25 is based on either a principal diagnosis of HIV Infection or a principle diagnosis of a significant HIV-related condition and a secondary diagnosis of HIV Infection.

If conditions for assignment to MDC 25 are met, MDC 25 takes precedence over MDCs 1-23.

HIV Infection

042 Human immuno virus dis

Significant HIV-related condition

Close Section

Illustration 4: MDC 25 (HIV) ICD-9 Code Assignment

MDC 12,13: Diseases & Disorders of Male/Female Reproductive System

If both MDC 12 and 13 show up, simply choose the MDC that matches the patient's gender – 12 for Male, 13 for female.

DRG Grouper Logic

Auto-open

MDC Lookup

When used as the principal diagnosis†, this code (054.19) would result in a DRG assignment from one of the following MDCs:

MDC 12: DISEASES & DISORDERS OF THE MALE REPRODUCTIVE SYSTEM (*if male*)

MDC 13: DISEASES & DISORDERS OF THE FEMALE REPRODUCTIVE SYSTEM (*if female*)

MDC 25: HUMAN IMMUNODEFICIENCY VIRUS INFECTIONS (*if HIV is a secondary diagnosis*)

† And assuming there are no resource-intensive procedures that would assign a DRG from the PRE-MDC.

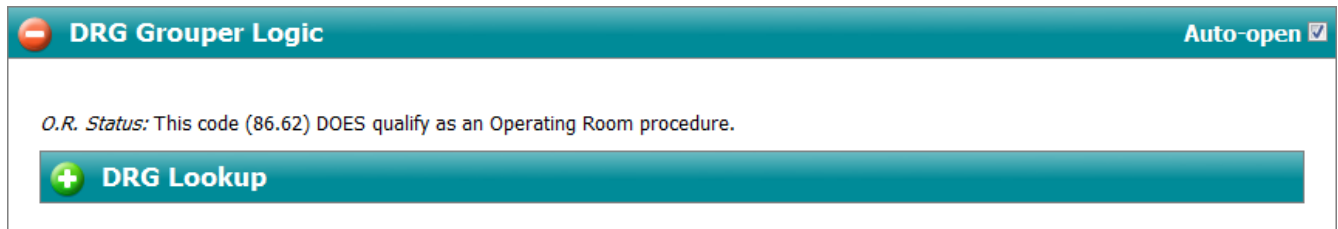
DRG Lookup

Complication/Comorbidity (CC) Information

Step 2: Find out if any Operating Room (O.R.) procedures were performed.

After finding an MDC, the next step is to find out if you're looking at the Surgical DRGs or Non-Surgical ones. To do this, look at the code pages for each of the procedures performed and pop open the "DRG Grouper Logic" section. Then look at the O.R. Status. Only one O.R. procedure is needed to qualify for a Surgical DRG instead of a Non-Surgical one.

For example, 86.62 (Skin graft to hand) *does* qualify as an O.R. Procedure:



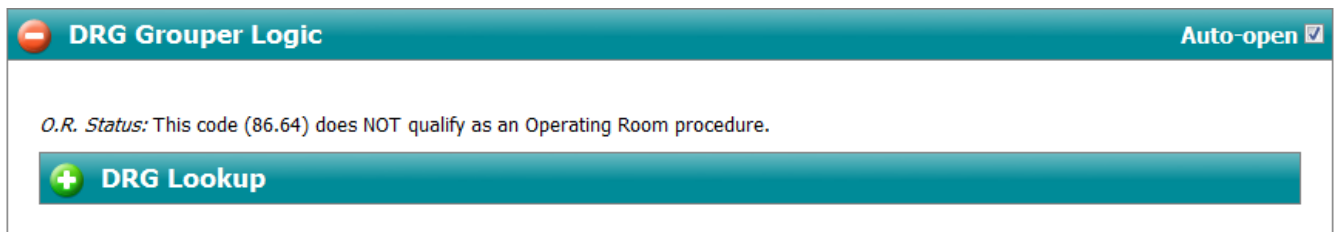
DRG Grouper Logic Auto-open

O.R. Status: This code (86.62) DOES qualify as an Operating Room procedure.

DRG Lookup

Illustration 6: "DRG Grouper Logic" section for code 86.62

But 86.64 (Hair transplant) does *not*:



DRG Grouper Logic Auto-open

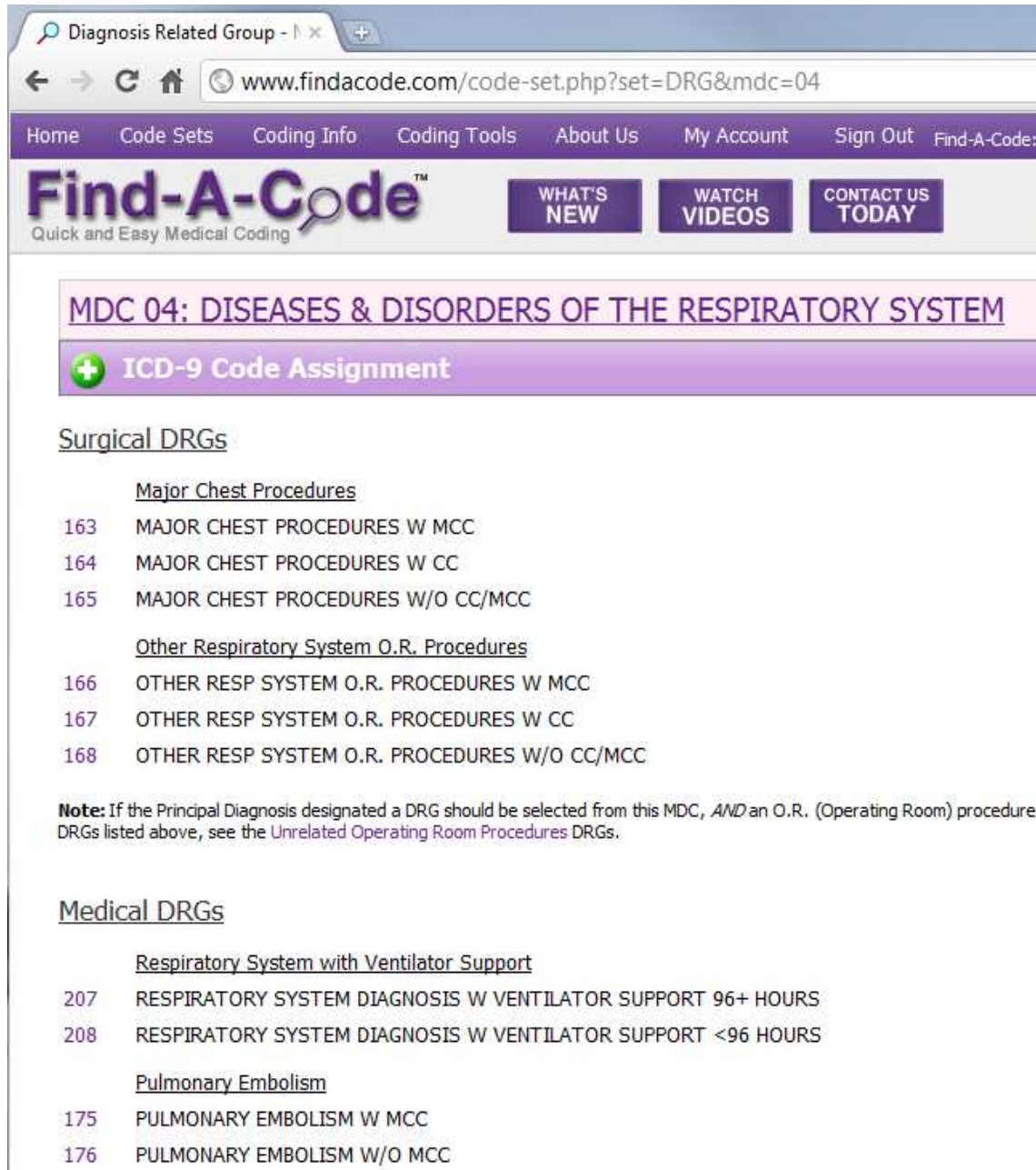
O.R. Status: This code (86.64) does NOT qualify as an Operating Room procedure.

DRG Lookup

Illustration 7: "DRG Grouper Logic" section for code 86.64

Step 3: Find the applicable DRG from the MDC

Return to the MDC that you found in step 1. Find the list of “Surgical DRGs” or “Medical DRGs”, according to the result of step 2.



Diagnosis Related Group - 1 x +

www.findacode.com/code-set.php?set=DRG&mdc=04

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MDC 04: DISEASES & DISORDERS OF THE RESPIRATORY SYSTEM

+ ICD-9 Code Assignment

Surgical DRGs

Major Chest Procedures

163 MAJOR CHEST PROCEDURES W MCC
164 MAJOR CHEST PROCEDURES W CC
165 MAJOR CHEST PROCEDURES W/O CC/MCC

Other Respiratory System O.R. Procedures

166 OTHER RESP SYSTEM O.R. PROCEDURES W MCC
167 OTHER RESP SYSTEM O.R. PROCEDURES W CC
168 OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC

Note: If the Principal Diagnosis designated a DRG should be selected from this MDC, *AND* an O.R. (Operating Room) procedure DRGs listed above, see the Unrelated Operating Room Procedures DRGs.

Medical DRGs

Respiratory System with Ventilator Support

207 RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
208 RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS

Pulmonary Embolism

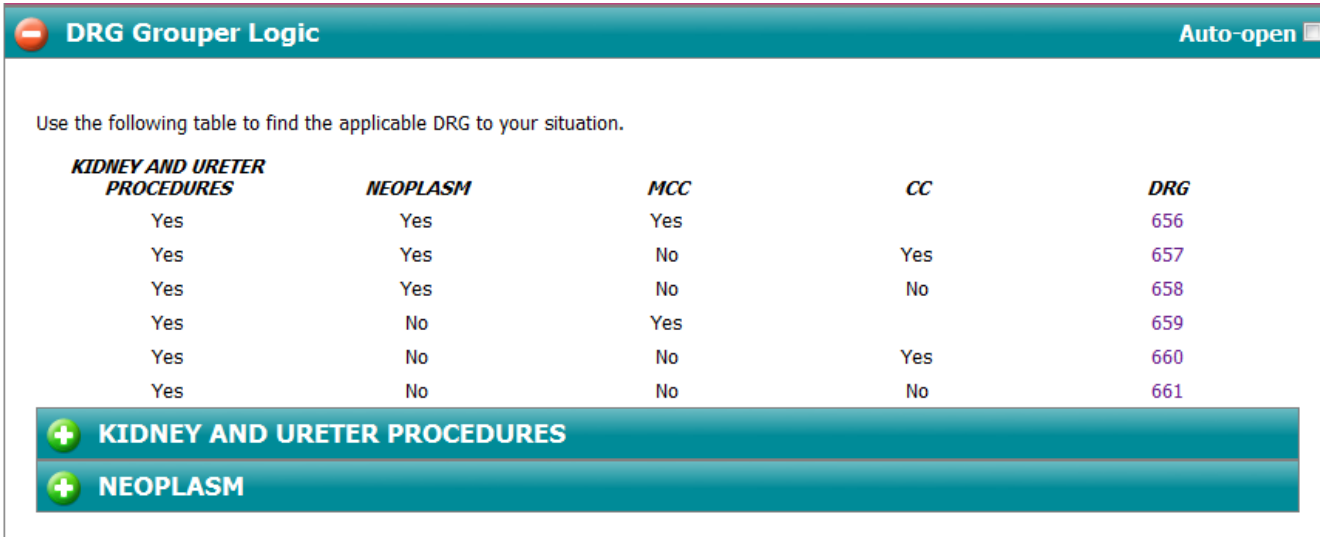
175 PULMONARY EMBOLISM W MCC
176 PULMONARY EMBOLISM W/O MCC

Illustration 8: MDC 04 Surgical and Medical DRGs

Go down the list of DRGs and find the first that applies to your case. You may be able to rule out the DRGs simply by the DRG's title (for example, if you know it was a Medical DRG from MDC 04, and there was not Ventilator Support, then you can skip over DRGs 207 & 208). Otherwise, click on a DRG to see the logic table for the DRG.

DRG Logic Tables

In a logic table, each column represents a condition, until the final column, which lists the resultant DRG if the conditions are met. For example, Figure # shows the logic table for DRGs 656-661:



DRG Grouper Logic Auto-open

Use the following table to find the applicable DRG to your situation.

<i>KIDNEY AND URETER PROCEDURES</i>	<i>NEOPLASM</i>	<i>MCC</i>	<i>CC</i>	<i>DRG</i>
Yes	Yes	Yes		656
Yes	Yes	No	Yes	657
Yes	Yes	No	No	658
Yes	No	Yes		659
Yes	No	No	Yes	660
Yes	No	No	No	661

+ KIDNEY AND URETER PROCEDURES

+ NEOPLASM

Illustration 9: Logic table for DRGs 656-661

The first column is “Kidney and Ureter Procedures”, and all of the rows list “Yes” for that condition – which means that in order to qualify for DRGs 656-661, you need to have a procedure from the “Kidney and Ureter Procedures” section, conveniently located below the logic table. If the current case does *not* have a procedure from this section, then you need to move on to the next set of DRGs in the MDC. If the current case *does* have a Kidney/Ureter procedure, then you need to see which of the other conditions the case satisfies. In this case, a Neoplasm diagnosis causes assignment to DRGS 656-658; absence of neoplasm causes assignment to DRGS 659-661. A very common set of conditions are whether or not complications were present – the CCs/MCCs (covered next).

Complications and Comorbidities

The cost of treating a patient can vary widely if there are other complications present. DRGs account for this by often making a designation between cases that have complications and those that don't; this is done by categorizing these complicating secondary diagnoses into “Complications and Comorbidities” (CCs), and “Major Complications and Comorbidities” (MCCs). It's pretty easy to tell if a secondary diagnosis acts as a CC/MCC – simply go to each codes' page, and look in the “DRG Grouper Logic” section, under “Complication/Comorbidity (CC) Information”. Here is the CC info section for ICD9 code 001.0 (Cholera):

DRG Grouper Logic Auto-open

- + MDC Lookup
- + DRG Lookup
- **Complication/Comorbidity (CC) Information**

CC/MCC Status: CC

When used as a *secondary diagnosis*, this code (001.0) DOES create a Complication/Comorbidity (CC) - *IF* the principal diagnosis does *not* appear in the 'Principal Diagnosis Exclusions' list below (otherwise it is treated as a non-CC).

Principal Diagnosis Exclusions (for 001.0 as Secondary Diagnosis)

When used as a *secondary diagnosis* with one of the following principal diagnosis codes, this code (001.0) does NOT create a CC or MCC (is excluded):

001.0 Cholera d/t vib cholerae	001.1 Cholera d/t vib el tor	001.9 Cholera NOS
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Secondary Diagnosis Exclusions (for 001.0 as Principal Diagnosis)

When this code (001.0) is used as a *principal diagnosis*, the following secondary diagnosis codes do NOT create a CC or MCC (are excluded):

001.0 Cholera d/t vib cholerae	001.1 Cholera d/t vib el tor	001.9 Cholera NOS
005.0 Staph food poisoning	005.3 Food pois: clostrid NEC	005.4 Food pois: v. parahaem
005.81 Food poisn d/t v. vulnif	005.89 Bact food poisoning NEC	009.0 Infectious enteritis NOS
009.2 Infectious diarrhea NOS		

Illustration 10: Complication/Comorbidity (CC) Info section for code 001.0

The first paragraph shows the CC/MCC status – in this case, a secondary diagnosis of Cholera *does* act as a complication (CC). However, there are some exceptions, such as when the secondary diagnosis is simply the same as the principal diagnosis or (more likely) when treatment of a secondary diagnosis would be included in treating the principal diagnosis.

Principal Diagnosis Exclusions – this is the paragraph you'll need to check if you're looking at a secondary diagnosis and want to see if it acts as a complication or if it is excluded (contained as part of the principal diagnosis). In this case, the excluded codes are other manifestations of Cholera.

Secondary Diagnosis Exclusions – if you want, you can also check the principal diagnosis' code page to see which secondary diagnoses do not act as complications. In this case, if the Principal Diagnosis is Cholera (001.), a secondary diagnosis of Staph food poisoning (005.0) isn't really a complication, and as such is excluded from being a CC.

There can be several secondary diagnoses for a case, and it only takes *one* to cause assignment to a CC or MCC DRG.

Hospital Acquired Conditions (HACs)

There are also a set of complicating diagnoses that are *not* considered CCs/MCCs if the diagnosis was not present on the patients' admission. These are for conditions that are easily preventable with proper care - for example, a “Foreign body accidentally left during a procedure” (998.4).

Complication/Comorbidity (CC) Information

CC/MCC Status: CC

When used as a *secondary diagnosis*, this code (998.4) DOES create a Complication/Comorbidity (CC) IF:

- the condition was present on the patient's admission (NOT hospital-acquired) *AND*
- the principal diagnosis does *not* appear in the 'Principal Diagnosis Exclusions' list below

otherwise it is treated as a non-CC.

Illustration 11: Hospital Acquired Condition example (code 998.4)

If the condition was *not* hospital-acquired (ie. the foreign body was present on admission), then such a diagnosis can still act as a complication. Just pay attention to the complication conditions to see whether or not the complication applies.

Other Uncommon Conditions

Occasionally there are conditions that deal with factors other than diagnoses and procedures – such as discharge status (alive vs. expired – see DRGs 280-285)

DRG Grouper Logic Auto-open

Use the following table to find the applicable DRG to your situation.

<i>ACUTE MYOCARDIAL INFARCTION</i>	<i>DISCHARGED ALIVE</i>	<i>MCC</i>	<i>CC</i>	<i>DRG</i>
Yes	Yes	Yes		280
Yes	Yes	No	Yes	281
Yes	Yes	No	No	282
Yes	No	Yes		283
Yes	No	No	Yes	284
Yes	No	No	No	285

+ ACUTE MYOCARDIAL INFARCTION

+ DISCHARGED ALIVE

Illustration 12: "DRG Grouper Logic" section for DRGs 280-285

Unrelated Operating Room Procedures

In the case that an Operating Room procedure was performed (as outlined in Step 2) but no Surgical DRGs from the MDC match, then an applicable DRG is selected from DRGs 981-989. The same procedure is used, starting at the top of the list and moving down until a DRG matches the case.

Ungroupable

In the event that no DRG matches the case, or there is not enough information to successfully match on, the Ungroupable DRG (999) is assigned.

Estimating Payment

After you have found the DRG to be assigned to your case, you can check out the expected payment amount using the “DRG Payment Calculator” section of the DRG page. These payments are based on the DRG relative weight but also adjusted to the cost of living and other area-specific factors, so make sure to update your Client/Fee Schedule information with the proper Hospital Provider Number and CBSA (state/region). Also be sure to specify whether or not your facility qualifies for the quality data reporting initiatives (RHQDAPU and HOP QDRP)

DRG Payment Calculator Auto-open

Note: This calculator gives only an estimate of payment. It is not to be relied upon for exact payment.

Provider: Unadjusted

Calculations made using *full* update amounts.

To see provider-specific calculations here, please enter your **Hospital Provider Number** into your Client/Fee Schedule on the [My Account](#) page.

Total Federal Operating Payment + Total Federal Capital Payment	= Total Federal Payment
\$5,521.28 + \$446.62	= \$5,967.90

+ Total Federal Operating Payment: \$5,521.28

+ Total Federal Capital Payment: \$446.62

A few things to remember:

- A lot of the information to do the DRG grouping is built in to the FindACode system. If something doesn't make sense, try reading the explanatory text.
- Always work your way *down* lists. Higher items have precedence over lower ones, and will also result in a higher payment, because they indicate a more severe or resource-intensive case.
- Watch out for those complication exclusions!