In many cases, Payer employs Medicare Severity Diagnosis Related Groups methodology (MS-DRG) to pay inpatient claims. This reimbursement system was created by CMS and implemented in 2007 under the Medicare Inpatient Prospective Payment System (IPPS) to better take into consideration the severity of a patient’s condition.

Under CMS, each DRG is assigned a relative weight based upon charge data for all Medicare inpatient charges. Each hospital has a customized base rate designed to adjust payment commensurate with the cost of providing services for that facility. The type of hospital and the wage index for the geographic area determines the hospital base rate. CMS updates the base rate and DRG relative weight information annually effective October 1 of each year.

Payer uses the CMS MS-DRG approach in two ways. In many cases a negotiated fee schedule is included in the contract. In this situation, the CMS MS-DRG grouper is used to determine the appropriate DRG to be assigned for payment purposes. Payer uses the most recent MS-DRG grouper (effective October 1) to assign the DRG. The allowed amount will be determined by the negotiated fee schedule.

In other cases, the contracted rates are based on a percentage of the most current CMS MS-DRG value. In this situation, the MS-DRG grouper and pricer are used to determine the most appropriate DRG and allowed amount using the most current CMS version (effective October 1) and applying a negotiated factor.

Facility providers are expected to follow CMS Requirements and update billing practices according to the newest updates required for the date of service being billed.

**DRG Assignment and Payment**

DRG’s are assigned using the following key elements from the UB-04 submitted by the facility for a patient:

1. **Principal Diagnosis and Up to 8 Additional Diagnoses (ICD-9 and October 2015 ICD-10)**
   - Principal diagnosis are divided into 25 Major Diagnostic Categories (MDC) that typically correspond to a single organ system with some exceptions.
   - Some MS-DRGs are split into multiple DRG’s based on whether secondary and additional diagnosis has been categorized as having Comorbidity (non-CC).
   - MCC’s reflect the highest level of severity and indicate a higher usage of resources and typically result in higher payment.
   - CC’s reflect the next lesser level of severity.
   - Medical DRG’s are assigned based on Diagnosis only. For example neoplasm, specific conditions related to the anatomical site, symptoms and other diagnoses where no operative procedure is performed. Medical categories include intracranial hemorrhage or cerebral infarction with MCC (MS-DRG 064).

2. **Principal Procedure and Up to 5 Additional Procedure Codes**
   - Principal procedure is the procedure that is typically necessary in treating a complication or performed for a definitive treatment of a condition. A principal procedure cannot be for diagnostic or exploratory purposes.
   - Pre-MDC MS-DRG’s
     - In some cases certain patient groups are resource intensive and are put into a separate group rather than being assigned a principal diagnosis driven MDC. These Pre-MDC MS-DRG’s include organ transplants and Implants of a Heart...
Assist System (MS-DRG’s 001 and 002) and are assigned based on the procedure performed. Principal Diagnosis is not taken into consideration.

- Operating Room Procedures
  - If a patient is not assigned to a Pre-MCD MS-DRG the patient is then classified (after consideration of diagnosis) by whether they had an operating room procedure.

- Procedures used as Proxy
  - CMS identified several procedures or device codes such as implants that increased complexity and could be considered as “proxy” for a lack of MCC or CC secondary diagnosis codes. A cochlear implant would be an example of this. The presence of the implant device will result in a higher weight and “stand in place” of a secondary diagnosis by nature of the complexity of the placement of the device. In the case of the cochlear implant the patient undergoing a major head or neck procedure with the implant without an MCC or CC are assigned the same MS-DRG as the patient with an MCC or CC who is undergoing a Major Head or Neck Procedure.

- Un-related Operating Room Procedures MS-DRG’s
  - These are assigned when the case has an OR procedure unrelated to the Principal Diagnosis within the MDC for the procedure.

3. Patient Gender
4. Discharge Status

Each hospital stay may only have one MS-DRG assignment based on the key elements listed above.

**NOTE:** MS-DRG submitted by the facility is not taken into consideration for the payment of the claim. It is crucial that the facility indicates and assigns accurately all of the key elements listed to ensure accurate payment based on MS-DRG methodology.