VALIDATION OF DRG 14

Specific Cerebrovascular Disorders Except Transient Ischemic Attacks

RICHARD P. KUSSEROW
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE: The purpose of this inspection was to conduct a review of hospital discharge claims paid under Diagnosis Related Group (DRG) 14, Specific Cerebrovascular Disorders Except Transient Ischemic Attacks.

BACKGROUND: The Office of Inspector General (OIG) analyzed all DRGs to determine the potential for erroneous payment based on incorrect or manipulative coding. Three DRGs, including DRG 14, were selected for review. This report deals only with the findings related to DRG 14. A sample of 10 hospitals in Region IX was selected for the inspection.

MAJOR FINDINGS: Over 15 percent of the cases reviewed were erroneously assigned to DRG 14. This resulted in $108,353 in net overpayments to the 10 hospitals reviewed. The projected net overpayment for all hospitals in the San Francisco region is $5,231,871. If these findings are representative of the nation, the national impact would be approximately $31.5 million annually.

The primary causes of the erroneous DRG assignments and overpayments to the hospitals include:

- physician failure to correctly identify the principal diagnosis or to state it with sufficient specificity, resulting in vague diagnoses which are subject to incorrect coding;
- insufficient documentation in the medical record to substantiate clinical diagnoses;
- variable coding practices prompting improper coding of the principal diagnosis by hospital staff; and
- inaccurate diagnosis for stroke symptoms of some elderly patients with multiple disabilities, resulting in faulty principal diagnoses and frequent misassignment of the DRG.

RECOMMENDATIONS:

- The Health Care Financing Administration (HCFA) should advise all peer review organizations (PROs) of the vulnerability of DRG 14 and suggest focused reviews of DRG 14 cases at hospitals with high numbers of such claims.

The HCFA Response: By agreeing that DRG 14 is vulnerable and by emphasizing the PROs' 20 percent random audit, HCFA indicated its acceptance of this recommendation.

- The HCFA should instruct the PROs to initiate intensified educational efforts toward improving physician designation of principal diagnoses.

  The HCFA Response: The HCFA agreed with this recommendation. The OIG will distribute this report to the PROs.

- The HCFA should provide sufficient resources and monitoring of fiscal intermediaries to enhance their capability to provide complete claims data on request in a timely manner.

  The HCFA Response: According to HCFA, sufficient funding is not available to restructure fiscal intermediary data in a form more useful for OIG studies such as DRG 14. The OIG will work with HCFA to resolve these problems.

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INTRODUCTION

BACKGROUND

Under section 1886(d) of the Social Security Act, enacted by the Social Security Amendments of 1983 (P.L. 98-21), a prospective payment system (PPS) for Medicare payment of inpatient hospital services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis related groups (DRGs).

The DRGs are based on a coding classification using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). This classification system was designed for the collection of morbidity and mortality statistics and not for reimbursement purposes. Incorrect application of the ICD-9-CM codes can lead to incorrect payments to hospitals. The Office of Inspector General (OIG) therefore has been concerned with the validity of payments to hospitals under PPS.

Beginning in late 1984, the OIG undertook studies on the validity of reimbursement under PPS. All DRGs were analyzed initially to determine their potential for erroneous payment. Based on the results, three DRG categories were selected for review because they were thought to be particularly vulnerable to miscoding and other errors by the provider community--DRG 88 (Chronic Obstructive Pulmonary Disease), DRG 82 (Respiratory Neoplasms), and DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attacks). Together, these three DRG categories constitute approximately 6 percent of total PPS reimbursements. Reports on DRG 88 and DRG 82 have already been issued.

PURPOSE

This report focuses on DRG 14, emphasizing some of the special problems in diagnosing and coding stroke patients under PPS. In 1984, DRG 14 was the fourth most frequently occurring DRG and ranked third in total reimbursement.

DRG 14 CODING PROBLEMS

Diagnosis Is Often Difficult

Diagnosing stroke patients is often difficult, especially frail, elderly patients with a variety of chronic conditions. The conditions grouped into DRG 14 are closely related to

DRGs 15, 16, and 17. Faulty diagnosis or misunderstanding on the part of coders, intentional or otherwise, can lead to improper assignment and reimbursement of the DRG.
It is important to emphasize that the OIG is not second-guessing physician diagnoses when reviewing medical records to validate that the case has been assigned to an appropriate DRG. Rather, the purpose of the validation is to assure that the medical record contains adequate documentation to support the principal diagnosis, any co-morbidities and complications noted, and the sequencing of these. In pilot studies of DRG 14 conducted in 1984, the most common reason for misassignment was failure to provide such documentation. This inspection confirmed those preliminary findings.

Hospitals May Manipulate To Bring About DRG Creep

The term "DRG creep" is widely used by the provider community to describe the practice of diagnosing and coding conditions other than those justified by the medical record in order to obtain higher paying DRGs. It is, therefore, a concern of the OIG.

The DRG 14 is particularly vulnerable to creep activity because of the combined effect of the following issues:

- High Weight. The DRG 14 has a relative weight of 1.3527. The average relative weight for all medical DRGs is .9404. The relative weight multiplied by the blended payment amount specific to each hospital results in the reimbursement amount. Therefore, the higher the relative weight, the more reimbursement the provider receives. Because of this, there are incentives for hospitals and physicians to manipulate principal diagnoses and place claims in the DRG 14 category which properly belong in other diagnosis related groups.

- Documentation. The Uniform Hospital Discharge Data Set (UHDDS) defines principal diagnosis as "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The principal diagnosis determines the DRG assignment, and the physician is responsible for accurately attesting to it. Physicians, however, do not consistently apply the UHDDS definition of principal diagnosis in their documentation practices.

- Sequencing Inconsistencies. Sequencing is the order in which the discharge diagnoses are listed and depends upon the condition that was chiefly responsible for occasioning the patient's admission to the hospital.

Since not all coders will interpret and code the same information the same way, DRG 14 is vulnerable.

The combination of higher than average relative weight, lack of consistency by physicians in their documentation, and diverse interpretations of diagnostic information by coders produces a climate conducive to DRG creep.

Basic Coding Errors Are Common

At the time this inspection was initiated, little definitive work had been published regarding ICD-9-CM coding errors. Two studies by the Institute of Medicine in 1977 and 1980, however, found error rates of over 30 percent among hospital-coded data. Unfortunately, even though the provider community acknowledges a high error rate in coding, until recently there were few definitive studies to determine how coding errors translate into DRG errors.

METHODOLOGY

To verify that cases were properly coded and payments were correct, medical records were reviewed for a sample of medical discharges which had been reimbursed as DRG 14. A sample of 10 hospitals was identified from all PPS hospitals in Region IX. Since the number of DRG 14 discharges in the sample hospitals varied from 0 to 188, OIG staff reviewed all cases assigned to DRG 14 for discharges that occurred between October 1, 1983 and September 1, 1984. Some of the sample hospitals were under PPS for only a few months during this period, and one had no PPS cases. A total of 355 records and claims were reviewed. (Appendix A lists each hospital showing the number of beds, PPS start date, and size of sample.) It is not known how many of these cases were reviewed by peer review organizations (PROs) or what action the PROs may have taken. The California PRO was not designated until after the period covered by this inspection.

The 10 hospitals were selected from a computer-generated list of random numbers. Stratification of the hospitals was based on bed size, as follows:

- less than 100 beds - 2 hospitals
- 101 to 299 beds - 3 hospitals
- 300 or more beds - 5 hospitals

The inspection focused on a review of the complete medical record for each DRG 14 admission included in the sample. The fiscal intermediaries identified the DRG 14 claims and provided payment information. The DRG 14 review procedure was tested in a pilot study conducted in four Region IX hospitals during FY 1984.

Region IX contracted with the American Medical Records Association (AMRA) and the California Medical Records Association (CMRA) for the services of medical records specialists to review the DRG 14 cases. These groups are professional organizations of registered record administrators (RRAs) and accredited record technicians (ARTs) who manage medical record functions in health care facilities. The AMRA is also the credentialing body for medical record professionals. All ICD-9-CM code assignments made by the reviewers were verified by an RRA on the OIG staff. All cases in which the DRG assignment was changed or the hospital admission was questioned were reviewed by OIG staff physicians.

The following steps were carried out in the DRG validation process:

- Examine physician attestation sheets to determine principal and other diagnoses and procedures reported by the physician.
- Review medical records to determine if the information attested to by the physician is substantiated.
- Code the diagnoses and procedures.
- Abstract data from medical records onto the OIG's worksheet.
- Compare codes assigned by OIG reviewer to the codes on the medical record and bill.
- Identify medical records in which discrepancies have occurred.
- Photocopy the medical record for those cases which could result in a change of DRG assignment or denial of the admission.
- Refer records with errors in DRG assignment or questionable admission to a physician reviewer.

WHAT IS A STROKE?

According to several neurologists and other experts who were interviewed by the OIG inspection team, a stroke, or cerebrovascular accident (CVA), occurs when there is a blockage or restriction of normal blood supply to the nerve cells of the brain. This blockage may result in injury to the nervous system and thus affect body functioning, as manifested by paralysis, loss of sensation, visual or speech problems, or cognitive/emotional disturbances. Strokes are commonly caused by either (1) a blood clot formed in one of the arteries of the brain (cerebral thrombosis), (2) a clot formed in the heart or in a blood vessel of the neck which travels to the brain and obstructs the normal flow of blood (cerebral embolism), or (3) bleeding through weak spots or aneurysms in a cerebral blood vessel (cerebral hemorrhage).

Physicians emphasized the difficulty involved in diagnosing stroke patients. Frequently, other unrelated conditions, such as hypoglycemia, benign tumors, subdural hematoma, and epilepsy, can cause symptoms that resemble strokes. For other patients, particularly elderly individuals with complicating diseases, precise diagnosis of a stroke is not an easy task.

The CVA is classified clinically according to the duration of symptoms. If the symptoms of a stroke are completely resolved within 24 hours, the condition is called a transient ischemic attack (TIA). If the stroke lasts longer than 24 hours, it is a complete stroke, or CVA. A CVA may be major or minor according to the degree of neurological impairment.

Treatment given during, or immediately after, a major stroke is designed to monitor the patient and prevent further complications. This includes steps to prevent further neurological or coronary damage. Once the acute phase has passed, the patient begins a program of rehabilitation and supportive care.

Depending on the location and type, TIAs are treated with drug therapy or vascular surgery. Treatment for a TIA can be more aggressive than for an actual CVA since the objective is to prevent a CVA from occurring.

FINDINGS

SIGNIFICANT OVERPAYMENTS RESULTED FROM ERRORS IN DRG ASSIGNMENT

Of the 355 records reviewed, 55 were found to be assigned erroneously to DRG 14, and 3 represented inappropriate admissions. These results are summarized in the following table:

DRG 14 CLAIMS

Percent of all cases in error	15.5
Total overpayment for 10 hospitals	$ 108,353
Projected overpayment, Region IX	5,231,871
Projected national overpayment*	$31,538,229

*Appendix B shows the data used to calculate the cost avoidance projections.

Hospital payments are based upon the weight of the DRG multiplied by the hospital's blended rate and adjusted for the beneficiary's deductible and other variables. The weight of each correct DRG was subtracted from the weight of DRG 14 and the result multiplied by the hospital's blended rate to arrive at the amount overpaid.

Most of the identified errors resulted in a lower weight being assigned. Coding changes which did not affect the DRG assignment were not counted as errors and therefore are not identified in this report. An additional amount of $15,425 was paid for three admissions determined not to be medically necessary. This amount was not counted, however, in the total. Details of the overpayment calculation for each case can be found in Appendix C.

MOST ERRORS INVOLVED INCORRECT OR NONSPECIFIC IDENTIFICATION OF THE PRINCIPAL DIAGNOSIS

In 44 (80 percent) of the erroneous cases, the DRG was based on a principal diagnosis attested to by the attending physician and coded within the medical record. In each of these cases, the principal diagnosis shown on the attestation form did not match the correct principal diagnosis as substantiated by the documentation in the medical record. Appendix D lists the types of errors which affect DRG assignment.

The first step in the assignment of a case to a particular DRG is the designation by the attending physician of the principal diagnosis, secondary diagnoses, and procedures performed. If the physician is unaware of the UHDDS definition of principal diagnosis or is inconsistent in applying it, erroneous DRG assignments are inevitable.

The OIG inspection revealed that sometimes a patient may be given a tentative diagnosis of a TIA and may be discharged within 2 or 3 days. However, the TIA may extend and become a CVA. Often, the patient is then readmitted with a CVA as the principal diagnosis. Patients also may be treated differently depending on their age and general condition. Older, more debilitated patients often exhibit CVA symptoms and are given a tentative diagnosis of CVA. Such patients are not always treated aggressively, which might paradoxically reveal a less severe condition. Thus, they are discharged with a principal diagnosis "after study" of CVA when, in fact, no real study was done, and the patients actually had TIAs or some different condition. Conversely, younger patients with tentative initial diagnoses of TIA are usually given quite aggressive treatment. During the course of such treatment, the diagnosis may be changed from TIA to a more serious CVA condition. This does not mean that all debilitated patients should be given extensive testing, but the failure to do so sometimes leads to improper diagnosis.

CODERS INCORRECTLY TRANSLATED PHYSICIANS' NARRATIVE IN 11 PERCENT OF ERRORS

In six (10.9 percent) of the miscoded cases reviewed, coders selected the wrong codes to translate the physicians' narrative descriptions of the principal diagnoses. In each of these cases, the physician had correctly identified and attested to the acute condition which necessitated admission. The error was made by the coder and was not identified in any subsequent review done by the hospital. It was not within the scope of this inspection to determine whether or not the coding errors were intentional.

THREE ADMISSIONS WERE UNNECESSARY

In addition to errors in DRG assignments, three cases reviewed by OIG physicians were found to lack sufficient documentation to justify admission to the hospital. The total dollar amount of unnecessary admissions was $15,425. However, this figure has not been included in the calculation of total error amounts.

The following charts summarize the findings in the sample hospitals:

ERROR RATES AND OVERPAYMENT

HOSP.	SAMPLE SIZE	# REASS.	# UNNEC. ADMISS.	% ERROR	NET OVERPAYMENT
A	46	7	1	15.2	$ 13,334
B	185	26	2	14.1	60,092
C	9	1	0	11.1	1,467
D	18	2	0	11.1	5,688
E	1	0	0	0	0
F	9	2	0	22.2	4,154
G	44	8	0	18.2	18,631
H	0	0	0	0	0
I	20	4	0	20.0	2,581
J	23	5	0	21.7	2,406
Totals	355	55	3	15.5	$108,353

REASONS FOR OVERPAYMENT

	Total	Percent Of Errors	Percent Of All Cases Reviewed
Physician documentation error; medical record does not substantiate diagnosis; or recording of vague diagnoses, subject to misinterpretation by coding clerks	44	80.0	12.4
Coding error resulting in miscoding of principal diagnosis	6	10.9	1.7
Other types of coding errors	5	9.1	1.4
Total Coding Errors	55	100.0	15.5

RECOMMENDATIONS

RECOMMENDATION #1--INITIATE AN EDUCATIONAL PROGRAM FOR PHYSICIANS

FINDING: Physicians often fail to correctly identify the principal diagnosis or state it with sufficient specificity. This results in vague diagnoses which are subject to incorrect coding.

RECOMMENDATION: The Health Care Financing Administration should initiate an educational program to improve physician documentation and designation of principal diagnoses with an emphasis on (1) requiring the UHDDS definition as opposed to final diagnosis, discharge diagnosis, or primary diagnosis; (2) the importance of specificity in identifying the principal diagnosis; and (3) the proper sequencing of the principal and secondary diagnoses.

This program should incorporate, at a minimum, the following elements:

- The PRO contact with individual physicians and medical staff.

- Utilization of professional and specialty organizations of physicians in disseminating information through national meetings, seminars, and publications.

- The HCFA and/or PRO contact with hospital and medical record administrators to inform them of their responsibilities whenever the physician's designation of principal diagnosis is in error according to UHDDS guidelines. In these situations, coders should consult with the attending physician, present UHDDS guidelines, and request that he or she sign an amended attestation. Interaction between the medical record department and the physician has been a long-standing and necessary process which should not change under PPS. Likewise, coders should review the entire medical record to identify the principal diagnosis, secondary diagnoses and procedures performed rather than simply assigning codes to the physician's narrative diagnoses. Although the attending physician is ultimately responsible for attesting to the principal diagnosis, secondary diagnoses, and procedures performed, it is in the best interest of the hospital to bring errors to the physician's attention, given the fact that the hospital may be liable and the physician may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

THE HCFA RESPONSE: The HCFA agreed with this recommendation. The OIG will distribute this report to the PROs.

RECOMMENDATION #2--ADVISE THE PROs OF THE VULNERABILITY OF DRG 14 AND REQUIRE FOCUSED REVIEWS

FINDING: Regarding the identification of patterns of abuse, this inspection showed that such patterns are clearly evident when many cases in a single DRG are reviewed. Patterns may not be equally obvious in PRO reviews of randomly selected cases of all DRGs.

RECOMMENDATION: The HCFA should advise the PROs of the vulnerability of DRG 14 and should require PROs to conduct focused reviews in hospitals with higher than average numbers of cases grouped to DRG 14. When a potentially abusive case is identified, a number of other cases in the same DRG should be reviewed.

THE HCFA RESPONSE: By agreeing that DRG 14 is vulnerable and by emphasizing the PROs' 20 percent random audit, HCFA indicated its acceptance of this recommendation.

RECOMMENDATION #3--INCREASE MONITORING OF FISCAL INTERMEDIARY PERFORMANCE

FINDING: Fiscal intermediary data were incomplete and turnaround time was slow.

RECOMMENDATION: The HCFA should provide sufficient resources and adequate monitoring of fiscal intermediaries to enhance their capability to provide complete claims data in a timely manner.

THE HCFA RESPONSE: According to HCFA, sufficient funding is not available to restructure fiscal intermediary data in a more useful form. The OIG will work with HCFA to resolve this problem.

APPENDIX A

CHARACTERISTICS OF SAMPLE HOSPITALS

DRG 14--SPECIFIC CEREBROVASCULAR DISEASE EXCEPT TIA

HOSPITAL	BED SIZE	PPS START DATE	DATE INSPECTION BEGUN	SAMPLE SIZE
A	300	June 1984	April 24, 1985	46
B	300	October 1983	April 15, 1985	185
C	693	July 1984	April 17, 1985	9
D	209	June 1984	April 3, 1985	18
E	35	July 1984	May 24, 1985	1
F	55	January 1984	April 9, 1985	9
G	116	January 1984	April 20, 1985	44
H	409	September 1984	-	0
I	343	July 1984	February 4, 1985	20
J	140	April 1984	February 5, 1985	23

METHOD FOR PROJECTING COST AVOIDANCE

The following table presents the data used to calculate the cost avoidance projections:

Strata	Hosp.	# of Records	# of Errors	Amount Errors (Dollars)	Errors per Record Reviewed (Dollars)
100 Beds or less	E	1	0	0	0
	F	9	2	4,154	462
101-299 Beds	D	18	2	5,688	316
	G	44	8	18,631	423
	J	23	5	2,406	105
300+ Beds	A	46	7	13,334	290
	B	185	26	60,092	325
	C	9	1	1,467	163
	H	0	0	0	0
	I	20	4	2,581	129
Totals (Unweighted)		355	55	108,353	305
(Weighted)		-	-	-	246

The estimated cost avoidance, for the time period studied, is $5,231,871 with a 90 percent confidence interval of $3,548,222 to $6,915,519. An estimated savings of $31,538,229 would result from projecting the Region IX results to the Nation. This figure has a 90 percent confidence interval of $21,407,476 to $41,668,981. The average error rate, weighted for the number of records in each hospital and adjusted for the stratification, for coding within this DRG is 13.9 percent. The coefficient of variation for these data is 19.56 percent.

APPENDIX C

ANALYSIS OF DRG 14 CLAIMS BY HOSPITAL AND CASE

HOSP.	CASE NO.	ORIG. DRG	REV. DRG	ORIG. WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
A	1	14		1.3527			$4,183	$4,183	$0
	2	14		1.3527			$4,183	$4,183	$0
	3	14		1.3527			$4,183	$4,183	$0
HOSP.	4	14		1.3527			$4,183	$4,183	$0
BLENDED	5	14	16	1.3527	0.8592	DENY/*	$4,183	$2,657	$1,526
RATE	6	14		1.3527			$4,183	$4,183	$0
	7	14		1.3527			$4,183	$4,183	$0
$3092.33	8	14		1.3527			$4,183	$4,183	$0
	9	14		1.3527			$4,183	$4,183	$0
	10	14		1.3527			$4,183	$4,183	$0
	11	14		1.3527			$4,183	$4,183	$0
	12	14	15	1.3527	0.6673	*	$4,183	$2,063	$2,120
	13	14		1.3527			$4,183	$4,183	$0
	14	14		1.3527			$4,183	$4,183	$0
	15	14	65	1.3527	0.4857	*	$4,183	$1,502	$2,681
	16	14		1.3527			$4,183	$4,183	$0
	17	14		1.3527			$4,183	$4,183	$0
	18	14		1.3527			$4,183	$4,183	$0
	19	14		1.3527			$4,183	$4,183	$0
	20	14		1.3527			$4,183	$4,183	$0
	21	14		1.3527			$4,183	$4,183	$0
	22	14		1.3527			$4,183	$4,183	$0
	23	14		1.3527			$4,183	$4,183	$0
	24	14		1.3527			$4,183	$4,183	$0
	25	14		1.3527			$4,183	$4,183	$0
	26	14		1.3527			$4,183	$4,183	$0
	27	14		1.3527			$4,183	$4,183	$0
	28	14		1.3527			$4,183	$4,183	$0
	29	14		1.3527			$4,183	$4,183	$0
	30	14		1.3527			$4,183	$4,183	$0
	31	14		1.3527			$4,183	$4,183	$0
	32	14		1.3527			$4,183	$4,183	$0
	33	14		1.3527			$4,183	$4,183	$0
	34	14		1.3527			$4,183	$4,183	$0
	35	14		1.3527			$4,183	$4,183	$0
	36	14		1.3527			$4,183	$4,183	$0
	37	14		1.3386			$4,139	$4,139	$0
	38	14		1.3527			$4,183	$4,183	$0
	39	14	15	1.3386	0.6604	*	$4,139	$2,042	$2,097
	40	14	15	1.3527	0.6673	*	$4,183	$2,063	$2,120
	41	14	123	1.3527	1.136	*	$4,183	$3,513	$670
	42	14		1.3527			$4,183	$4,183	$0
	43	14		1.3527			$4,183	$4,183	$0
	44	14	15	1.3527	0.6673	*	$4,183	$2,063	$2,120
	45	14		1.3386			$4,139	$4,139	$0
	46	14		1.3527			$4,183	$4,183	$0
						TOTAL:	$192,287	$178,953	$13,334

REVIEW OF DRG 14 - REGION IX

HOSP. B	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
	1	14		1.3527			$5,621	$5,621	$0
	2	14		1.3527			$5,621	$5,621	$0
	3	14		1.3527			$5,621	$5,621	$0
HOSP.	4	14		1.3527			$5,621	$5,621	$0
BLENDED	5	14	296	1.3527	0.8979	*	$5,621	$3,731	$1,890
RATE	6	14		1.3527			$5,621	$5,621	$0
	7	14		1.3527			$5,621	$5,621	$0
4155.47	8	14		1.3527			$5,621	$5,621	$0
	9	14		1.3527			$5,621	$5,621	$0
	10	14		1.3527			$5,621	$5,621	$0
	11	14		1.3527			$5,621	$5,621	$0
	12	14		1.3527			$5,621	$5,621	$0
	13	14		1.3527			$5,621	$5,621	$0
	14	14		1.3527			$5,621	$5,621	$0
	15	14	138	1.3527	0.9297	*	$5,621	$3,863	$1,758
	16	14	89	1.3527	1.1029	*	$5,621	$4,583	$1,038
	17	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	18	14	34	1.3527	0.9927	*	$5,621	$4,125	$1,496
	19	14		1.3527			$5,621	$5,621	$0
	20	14		1.3527			$5,621	$5,621	$0
	21	14	425	1.3527	0.6812	*	$5,621	$2,831	$2,790
	22	14		1.3527			$5,621	$5,621	$0
	23	14		1.3527			$5,621	$5,621	$0
	24	14		1.3527			$5,621	$5,621	$0
	25	14		1.3527			$5,621	$5,621	$0
	26	14		1.3527			$5,621	$5,621	$0
	27	14		1.3527			$5,621	$5,621	$0
	28	14		1.3527			$5,621	$5,621	$0
	29	14		1.3527			$5,621	$5,621	$0
	30	14	24	1.3527	0.7279	*	$5,621	$3,025	$2,596
	31	14		1.3527			$5,621	$5,621	$0
	32	14		1.3527			$5,621	$5,621	$0
	33	14	244	1.3527	0.7729	*	$5,621	$3,212	$2,409
	34	14		1.3527			$5,621	$5,621	$0
	35	14		1.3527			$5,621	$5,621	$0
	36	14		1.3527			$5,621	$5,621	$0
	37	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	38	14	131	1.3527	0.6051	*	$5,621	$2,514	$3,107
	39	14		1.3527			$5,621	$5,621	$0
	40	14		1.3527			$5,621	$5,621	$0
	41	14		1.3527			$5,621	$5,621	$0
	42	14	24	1.3527	0.7279	*	$5,621	$3,025	$2,596
	43	14		1.3527			$5,621	$5,621	$0
	44	14		1.3527			$5,621	$5,621	$0
	45	14		1.3527			$5,621	$5,621	$0
	46	14		1.3527			$5,621	$5,621	$0

REVIEW OF DRG 14 - REGION IX

HOSP. B	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
	47	14		1.3527			$5,621	$5,621	$0
	48	14		1.3527			$5,621	$5,621	$0
	49	14		1.3527			$5,621	$5,621	$0
	50	14		1.3527			$5,621	$5,621	$0
	51	14		1.3527			$5,621	$5,621	$0
	52	14		1.3527			$5,621	$5,621	$0
	53	14		1.3527			$5,621	$5,621	$0
	54	14		1.3527			$5,621	$5,621	$0
	55	14		1.3527			$5,621	$5,621	$0
	56	14		1.3527			$5,621	$5,621	$0
	57	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	58	14	65	1.3527	0.4857	*	$5,621	$2,018	$3,603
	59	14		1.3527			$5,621	$5,621	$0
	60	14		1.3527			$5,621	$5,621	$0
	61	14		1.3527			$5,621	$5,621	$0
	62	14		1.3527			$5,621	$5,621	$0
	63	14		1.3527			$5,621	$5,621	$0
	64	14	416	1.3527	1.5504	*	$5,621	$6,443	($822)
	65	14		1.3527			$5,621	$5,621	$0
	66	14		1.3527			$5,621	$5,621	$0
	67	14		1.3527			$5,621	$5,621	$0
	68	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	69	14		1.3527			$5,621	$5,621	$0
	70	14		1.3527			$5,621	$5,621	$0
	71	14		1.3527			$5,621	$5,621	$0
	72	14		1.3527			$5,621	$5,621	$0
	73	14		1.3527			$5,621	$5,621	$0
	74	14	83	1.3527	0.9809	*	$5,621	$4,076	$1,545
	75	14		1.3527			$5,621	$5,621	$0
	76	14		1.3527			$5,621	$5,621	$0
	77	14		1.3527			$5,621	$5,621	$0
	78	14		1.3527			$5,621	$5,621	$0
	79	14	16	1.3527	0.8592	*	$5,621	$3,570	$2,051
	80	14		1.3527			$5,621	$5,621	$0
	81	14		1.3527			$5,621	$5,621	$0
	82	14		1.3527			$5,621	$5,621	$0
	83	14		1.3527			$5,621	$5,621	$0
	84	14	65	1.3527	0.4857	DENY/*	$5,621	$2,018	$3,603
	85	14		1.3527			$5,621	$5,621	$0
	86	14		1.3527			$5,621	$5,621	$0
	87	14		1.3527			$5,621	$5,621	$0
	88	no record							
	89	no record							
	90	14		1.3527			$5,621	$5,621	$0
	91	14		1.3527			$5,621	$5,621	$0
	92	14		1.3527			$5,621	$5,621	$0

REVIEW OF DRG 14 - REGION IX

HOSP. B	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
	93	14		1.3527			$5,621	$5,621	$0
	94	14		1.3527			$5,621	$5,621	$0
	95	14		1.3527			$5,621	$5,621	$0
	96	14		1.3527			$5,621	$5,621	$0
	97	14		1.3527			$5,621	$5,621	$0
	98	14		1.3527			$5,621	$5,621	$0
	99	14		1.3527			$5,621	$5,621	$0
	100	14		1.3527			$5,621	$5,621	$0
	101	14		1.3527			$5,621	$5,621	$0
	102	14		1.3527			$5,621	$5,621	$0
	103	14		1.3527			$5,621	$5,621	$0
	104	14		1.3527			$5,621	$5,621	$0
	105	14		1.3527			$5,621	$5,621	$0
	106	14		1.3527			$5,621	$5,621	$0
	107	14		1.3527			$5,621	$5,621	$0
	108	14		1.3527			$5,621	$5,621	$0
	109	14		1.3527			$5,621	$5,621	$0
	110	14		1.3527			$5,621	$5,621	$0
	111	14		1.3527			$5,621	$5,621	$0
	112	14		1.3527			$5,621	$5,621	$0
	113	14		1.3527			$5,621	$5,621	$0
	114	14		1.3527			$5,621	$5,621	$0
	115	14		1.3527			$5,621	$5,621	$0
	116	14		1.3527			$5,621	$5,621	$0
	117	14		1.3527			$5,621	$5,621	$0
	118	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	119	14		1.3527			$5,621	$5,621	$0
	120	14		1.3527			$5,621	$5,621	$0
	121	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	122	14		1.3527			$5,621	$5,621	$0
	123	14		1.3527			$5,621	$5,621	$0
	124	14		1.3527			$5,621	$5,621	$0
	125	14		1.3527			$5,621	$5,621	$0
	126	14		1.3527			$5,621	$5,621	$0
	127	14		1.3527			$5,621	$5,621	$0
	128	14		1.3527			$5,621	$5,621	$0
	129	14		1.3527			$5,621	$5,621	$0
	130	14		1.3527			$5,621	$5,621	$0
	131	14		1.3527			$5,621	$5,621	$0
	132	14		1.3527			$5,621	$5,621	$0
	133	14		1.3527			$5,621	$5,621	$0
	134	14		1.3527			$5,621	$5,621	$0
	135	14		1.3527			$5,621	$5,621	$0
	136	14		1.3527			$5,621	$5,621	$0
	137	14		1.3527			$5,621	$5,621	$0
	138	14		1.3527			$5,621	$5,621	$0

REVIEW OF DRG 14 - REGION IX

HOSP. B	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
	139	14		1.3527			$5,621	$5,621	$0
	140	14		1.3527			$5,621	$5,621	$0
	141	14	12	1.3527	1.1136	DENY/*	$5,621	$4,627	$994
	142	14	127	1.3527	1.0408	*	$5,621	$4,325	$1,296
	143	14		1.3527			$5,621	$5,621	$0
	144	14		1.3527			$5,621	$5,621	$0
	145	14		1.3527			$5,621	$5,621	$0
	146	14		1.3527			$5,621	$5,621	$0
	147	14		1.3527			$5,621	$5,621	$0
	148	14		1.3527			$5,621	$5,621	$0
	149	14		1.3527			$5,621	$5,621	$0
	150	14		1.3527			$5,621	$5,621	$0
	151	14		1.3527			$5,621	$5,621	$0
	152	14		1.3527			$5,621	$5,621	$0
	153	14		1.3527			$5,621	$5,621	$0
	154	14		1.3527			$5,621	$5,621	$0
	155	14		1.3527			$5,621	$5,621	$0
	156	no record							
	157	14		1.3527			$5,621	$5,621	$0
	158	14		1.3527			$5,621	$5,621	$0
	159	14		1.3527			$5,621	$5,621	$0
	160	14	320	1.3527	0.8123	*	$5,621	$3,375	$2,246
	161	14		1.3527			$5,621	$5,621	$0
	162	14	421	1.3527	0.6045	*	$5,621	$2,512	$3,109
	163	14		1.3527			$5,621	$5,621	$0
	164	14		1.3527			$5,621	$5,621	$0
	165	14		1.3527			$5,621	$5,621	$0
	166	14		1.3527			$5,621	$5,621	$0
	167	14		1.3527			$5,621	$5,621	$0
	168	14		1.3527			$5,621	$5,621	$0
	169	14		1.3527			$5,621	$5,621	$0
	170	14		1.3527			$5,621	$5,621	$0
	171	14		1.3527			$5,621	$5,621	$0
	172	14		1.3527			$5,621	$5,621	$0
	173	14		1.3527			$5,621	$5,621	$0
	174	14		1.3527			$5,621	$5,621	$0
	175	14		1.3527			$5,621	$5,621	$0
	176	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	177	14		1.3527			$5,621	$5,621	$0
	178	14		1.3527			$5,621	$5,621	$0
	179	14		1.3527			$5,621	$5,621	$0
	180	14		1.3527			$5,621	$5,621	$0
	181	14		1.3527			$5,621	$5,621	$0
	182	14	15	1.3527	0.6673	*	$5,621	$2,773	$2,848
	183	14		1.3527			$5,621	$5,621	$0
	184	14		1.3527			$5,621	$5,621	$0

REVIEW OF DRG 14 - REGION IX

HOSP. B	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
	185	14		1.3527			$5,621	$5,621	$0
	186	14		1.3527			$5,621	$5,621	$0
	187	14		1.3527			$5,621	$5,621	$0
	188	14		1.3527			$5,621	$5,621	$0
					TOTAL:		$1,039,904	$979,813	$60,092

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG DRG	CORR. DRG	ORIG. WEIGHT	CORRECT WEIGHT	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
C	1	14		1.3527			$7,650	$7,650	$0
	2	14	430	1.3527	1.0934	*	$7,650	$6,183	$1,467
	3	14		1.3527			$7,650	$7,650	$0
HOSPITAL	4	14		1.3527			$7,650	$7,650	$0
BLENDED	5	14		1.3527			$7,650	$7,650	$0
RATE	6	14		1.3527			$7,650	$7,650	$0
	7	14		1.3527			$7,650	$7,650	$0
$5655.31	8	14		1.3527			$7,650	$7,650	$0
	9	14		1.3527			$7,650	$7,650	$0
					TOTAL:		$68,850	$67,383	$1,467

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
D	1	14		1.3527			$6,073	$6,073	$0
	2	14		1.3527			$6,073	$6,073	$0
	3	14		1.3527			$6,073	$6,073	$0
HOSPITAL	4	14		1.3527			$6,073	$6,073	$0
BLENDED	5	14		1.3527			$6,073	$6,073	$0
RATE	6	14		1.3527			$6,073	$6,073	$0
	7	14		1.3527			$6,073	$6,073	$0
4489.38	8	14	15	1.3527	0.6673	*	$6,073	$2,996	$3,077
	9	14		1.3527			$6,073	$6,073	$0
	10	14		1.3527			$6,073	$6,073	$0
	11	14		1.3527			$6,073	$6,073	$0
	12	14		1.3527			$6,073	$6,073	$0
	13	14	244	1.3527	0.7711	*	$6,073	$3,462	$2,611
	14	14		1.3527			$6,073	$6,073	$0
	15	14		1.3527			$6,073	$6,073	$0
	16	14		1.3527			$6,073	$6,073	$0
	17	14		1.3527			$6,073	$6,073	$0
	18	14		1.3527			$6,073	$6,073	$0
					TOTAL:		$109,310	$103,622	$5,688

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG DRG	CORR. DRG	ORIG. WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
E	1	14	14	1.3527			$3,651	$3,651	$0
HOSP BLENDED RATE $2698.89									
					TOTAL:		$3,651	$3,651	$0

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
F	1	14		1.3527			$3,767	$3,767	$0
	2	14		1.3527			$3,767	$3,767	$0
	3	14		1.3527			$3,767	$3,767	$0
HOSPITAL	4	14		1.3527			$3,767	$3,767	$0
BLENDED	5	14	24	1.3527	0.7279	*	$3,767	$2,027	$1,740
RATE	6	14		1.3527			$3,767	$3,767	$0
	7	14	65	1.3527	0.4857	*	$3,767	$1,353	$2,414
2784.75	8	14		1.3527			$3,767	$3,767	$0
	9	14		1.3527			$3,767	$3,767	$0
					TOTAL:		$33,902	$29,748	$4,154

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG. DRG	CORR. DRG	ORIG WT.	CORR. WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
G	1	14		1.3527			$4,978	$4,978	$0
	2	14		1.3386			$4,926	$4,926	$0
	3	14		1.3527			$4,978	$4,978	$0
HOSPITAL	4	14		1.3386			$4,926	$4,926	$0
BLENDED	5	14	130	1.3527	0.9645	*	$4,978	$3,549	$1,429
RATE	6	14		1.3527			$4,978	$4,978	$0
	7	14		1.3527			$4,978	$4,978	$0
3679.83	8	no record							
	9	14		1.3386			$4,926	$4,926	$0
	10	14	15	1.3527	0.6673	*	$4,978	$2,455	$2,523
	11	14	15	1.3386	0.6604	*	$4,926	$2,430	$2,496
	12	14	15	1.3527	0.6673	*	$4,978	$2,455	$2,523
	13	14		1.3527			$4,978	$4,978	$0
	14	14		1.3386			$4,926	$4,926	$0
	15	14		1.3527			$4,978	$4,978	$0
	16	14		1.3527			$4,978	$4,978	$0
	17	14		1.3527			$4,978	$4,978	$0
	18	14		1.3527			$4,978	$4,978	$0
	19	14		1.3527			$4,978	$4,978	$0
	20	14		1.3527			$4,978	$4,978	$0
	21	14	15	1.3527	0.6673	*	$4,978	$2,455	$2,523
	22	14	15	1.3527	0.6673	*	$4,978	$2,455	$2,523
	23	14		1.3527			$4,978	$4,978	$0
	24	14		1.3527			$4,978	$4,978	$0
	25	14		1.3527			$4,978	$4,978	$0
	26	14	15	1.3527	0.6673	*	$4,978	$2,455	$2,523
	27	14		1.3527			$4,978	$4,978	$0
	28	14		1.3527			$4,978	$4,978	$0
	29	14	395	1.3527	0.7839	*	$4,978	$2,885	$2,093
	30	14		1.3527			$4,978	$4,978	$0
	31	14		1.3527			$4,978	$4,978	$0
	32	14		1.3527			$4,978	$4,978	$0
	33	14		1.3527			$4,978	$4,978	$0
	34	14		1.3527			$4,978	$4,978	$0
	35	14		1.3527			$4,978	$4,978	$0
	36	14		1.3527			$4,978	$4,978	$0
	37	14		1.3527			$4,978	$4,978	$0
	38	14		1.3527			$4,978	$4,978	$0
	39	14		1.3527			$4,978	$4,978	$0
	40	14		1.3527			$4,978	$4,978	$0
	41	14		1.3527			$4,978	$4,978	$0
	42	14		1.3527			$4,978	$4,978	$0
	43	14		1.3527			$4,978	$4,978	$0
	44	14		1.3527			$4,978	$4,978	$0
	45	14		1.3527			$4,978	$4,978	$0
					TOTAL:		$218,760	$200,129	$18,631

REVIEW OF DRG 14 - REGION IX

HOSPITAL	CASE NUMBER	ORIGINAL DRG	CORRECT DRG	ORIGINAL WEIGHT	CORRECT WEIGHT	ERROR	ACTUAL PAYMENT
H							
HOSPITAL BLENDED RATE		THIS HOSPITAL HAD A SAMPLE SIZE OF "0"					

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG. DRG	CORR. DRG	ORIG. WT.	CORRECT WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
I	1	14		1.3527			$4,676	$4,676	$0
	2	14	299	1.3527	0.9407	*	$4,676	$3,252	$1,424
	3	14		1.3527			$4,676	$4,676	$0
HOSPITAL	4	14		1.3527			$4,676	$4,676	$0
BLENDED	5	14		1.3527			$4,676	$4,676	$0
RATE	6	14		1.3386			$4,627	$4,627	$0
	7	14		1.3527			$4,676	$4,676	$0
3456.78	8	14	20	1.3527	1.3141	*	$4,676	$4,542	$134
	9	14		1.3386			$4,627	$4,627	$0
	10	14		1.3527			$4,676	$4,676	$0
	11	14	16	1.3527	0.8592	*	$4,676	$2,970	$1,706
	12	14		1.3527			$4,676	$4,676	$0
	13	14	416	1.3527	1.5504	*	$4,676	$5,359	($683)
	14	14		1.3527			$4,676	$4,676	$0
	15	14		1.3527			$4,676	$4,676	$0
	16	14		1.3527			$4,676	$4,676	$0
	17	14		1.3527			$4,676	$4,676	$0
	18	14		1.3527			$4,676	$4,676	$0
	19	14		1.3527			$4,676	$4,676	$0
	20	14		1.3527			$4,676	$4,676	$0
					TOTAL:		$93,422	$90,841	$2,581

REVIEW OF DRG 14 - REGION IX

HOSP.	CASE NO.	ORIG DRG	CORR. DRG	ORIG. WT.	CORRECT WT.	ERROR	ACTUAL PAY	REVISED PAY	DIFFERENCE
J	1	14	17	1.3527	0.8392	*	$3,834	$2,379	$1,455
	2	14		1.3527			$3,834	$3,834	$0
	3	14		1.3527			$3,834	$3,834	$0
	4	14		1.3527			$3,834	$3,834	$0
HOSPITAL	5	14		1.3527			$3,834	$3,834	$0
BLENDED	6	14		1.3527			$3,834	$3,834	$0
RATE	7	14		1.3527			$3,834	$3,834	$0
---	8	14		1.3527			$3,834	$3,834	$0
2834.41	9	14	15	1.3527	0.6673	*	$3,834	$1,891	$1,943
	10	14		1.3527			$3,834	$3,834	$0
	11	14		1.3527			$3,834	$3,834	$0
	12	14		1.3527			$3,834	$3,834	$0
	13	14	462	1.3527	1.8268	OTHER	$3,834	$5,178	($1,344)
	14	14		1.3527			$3,834	$3,834	$0
	15	14		1.3527			$3,834	$3,834	$0
	16	14		1.3527			$3,834	$3,834	$0
	17	14		1.3527			$3,834	$3,834	$0
	18	14		1.3527			$3,834	$3,834	$0
	19	14		1.3527			$3,834	$3,834	$0
	20	14	140	1.3527	0.7548	*	$3,834	$2,139	$1,695
	21	14		1.3527			$3,834	$3,834	$0
	22	14		1.3527			$3,834	$3,834	$0
	23	14	462	1.3527	1.8268	OTHER	$3,834	$5,178	($1,344)
					TOTAL:		$88,184	$85,779	$2,406

TYPES OF ERRORS WHICH AFFECT DRG ASSIGNMENT

- physician documentation error in attesting to principal diagnosis; medical record does not substantiate diagnosis(es); or recording of vague diagnosis, subject to misinterpretation
- physician error in documentation of operation(s)/ procedure(s)
- coding error - principal diagnosis miscoded
- coding error - procedure(s) miscoded
- coding error - additional diagnoses or procedures added
- coding error - diagnoses or procedures left off
- sequencing error - codes rearranged to change DRG assignment
- rehabilitation issue, billing error, etc.