DRG FAQs

(Version 1.0)

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What are DRGs?

DRGs stands for Diagnosis Related Groups. DRGs bundle or combine inpatient hospital services into a single group for each inpatient stay. The hospital services included in each DRG bundle represents the typical services provided across all hospitals for inpatients with similar reasons for admission.

How does DRGs work?

A DRG is how health insurance companies categorize hospitalization costs and determine how much to pay for a patient's hospital stay. Rather than paying the hospital for what it spent caring for a hospitalized patient, the health insurance company pays the hospital a fixed amount based on the patient's DRG.

What do DRGs cover?

Many types of services are included in the DRG, such as physician care, nursing care, therapies, radiology, pharmaceuticals, laboratory, room, meals, etc.

Are emergency care included in the DRG payment?

All claim activities including emergency reported on the day of admission have been included in DRG payment calculations

Are discharge medication covered under DRGs?

All discharge medication up to 7 days maximum are to be included in the DRG payments.

Are suites and VIP room charges included in the DRG payment?

DRGs provides a standardized payment for the services provided. Room charges are already incurred in the base rate calculations. Any additional room charges will be settled between the patient and the hospital. Hospitals, at their discretion, may offer a better rooms without charging the patient.

How does DRGs cater for patient hoteling?

Patient should be clinically and administratively discharged upon the completion of patient care. If the patient decides to continue to stay in the hospital, the patient should be billed separately from the DRG payments.

Can hospitals bill policy excluded services in DRGs?

Hospital services that were provided but are not covered in the insurance policy should not be reported as part of the DRG submission. Uncovered services will be settled between patient and hospital.

How are community based and visiting doctors billed in DRGs?

Clinicians' bills will be reported as part of the DRG claim submission by the hospital. Clinicians will not be billed separately from the DRG claim submission.

How are send-out services billed in DRGs?

Send out services are those cases where to patient is accompanied by the hospital to another facility to receive service. Payments for send out services should be arranged internally between hospital and the facility. The send out service will not be part of the DRG claim from the hospital.

What impact does DRGs have on healthcare?

The DRG system of payment encourages hospitals to become more efficient in treating patients and takes away the incentive for hospitals to over-treat patients.

Which providers are mandated to submit DRGs?

All DHA or DHCC Licensed Hospitals registered on eClaimLink submitting inpatient claims are mandated to submit DRGs for inpatient services.

What is the effective date for DRG implementation in Dubai?

The effective date for DRG implementation in Dubai is 1 September 2020.

How are DRG payments calculated?

The DRG payment system uses a series of parameters for calculating the specific payments to be made to hospitals for each inpatient stay: Base Rate, Relative Weights, Negotiation Bands, Outlier Payment, Transfer Payment, High Cost Payment.

How are claims paid under the DRG payment system?

DRG Payment =

(Base Rate X Relative Weight X Negot. Factor) + Outlier Payment + Transfer Payment + Add-On Payment

If Applicable

What is a Base Rate?

The base rate represents the DRG payment for the overall "average" hospital inpatient admission. The formula is:

$$\text{BaseRate} = \frac{\text{Total Payments for all Inpatient Cases}}{\text{Case} - \text{Mix Adjusted Number of Cases}}$$

What are Relative Weights?

Relative weights adjust the base rate for changes in the resources required to provide different hospital services as measured by the DRGs. The more resources used for the inpatient stay, the higher the relative Weight

What are Negotiation Bands?

This is the range (band) within which health insurance companies and individual hospitals are permitted to negotiate the base rate. One negotiation factor is allowed per hospital/insurer combination.

What is an Outlier Payment?

The purpose of outlier payments in the DRG payment system is to provide risk sharing for very costly cases. This enables the hospitals to be paid an extra amount, in addition to the regular IR-DRG payment, for treating patients who have very high costs during their inpatient stays in the hospital.
An outlier payment for an inpatient case is made to a hospital if and only if the cost of the case exceeds a predetermined threshold amount. Added to the regular IR-DRG payment to identify the very high cost cases that qualify for the extra outlier payment.

What are the components of the Outlier Payment?

There are 4 components:

- Target percentage of payments that are outlier payments (TPOP)
- Claim cost
- Marginal
- Threshold

What is the Target percentage of payments that are outlier payments (TPOP)?

The DRG inlier payment rates (Base Rate * Relative Weight) are adjusted downwards by the target percentage of total payments that are outlier payments (TPOP) in the market to account for the outlier payments. It creates a pool of money for insurers for paying for outlier cases and helps to ensure budget neutrality

How are Claim Cost Calculated?

In the absence of detailed hospital cost reporting allowing the determination of claim level costs, the costs for a claim must be imputed. The imputation is based on two components:

- A predetermined cost for each activity code
- The total number of activities billed on the claim

The methodology for calculating claim cost is as follows:

- Activity codes billed more than ten times during the period have cost set at the 25th percentile of payments*
- Remaining activity codes have cost set at 1.80 times the Abu Dhabi basic price.
- Codes not billed in Dubai more than 10 times and not on the HAAD price list are assigned a cost of 0 AED
- The cost for drugs is set at the value on the Ministry of Health Price List
- *On average 1.80 times larger than the basic price in Abu Dhabi.

What is a Transfer Payment?

Hospitals sometimes transfer patients to other hospitals. Transfer payments allow for both hospitals treating the patient to be paid fairly for the care provided.
Transfers of inpatients within a hospital system, where both the transferring hospital and the receiving hospital are owned by the same company, will not receive a transfer payment; only the DRG payment will be made.

How are transfer cases (not within the same hospital group) paid under DRGs?
When a patient is transferred from hospital A to hospital B, Hospital A submits a DRG claim that is paid per diem where the first hospital day is paid at 100% and subsequent days paid at 50% capped at the DRG inlier payment. Hospital B submits a full DRG claim for the episode in Hospital B.

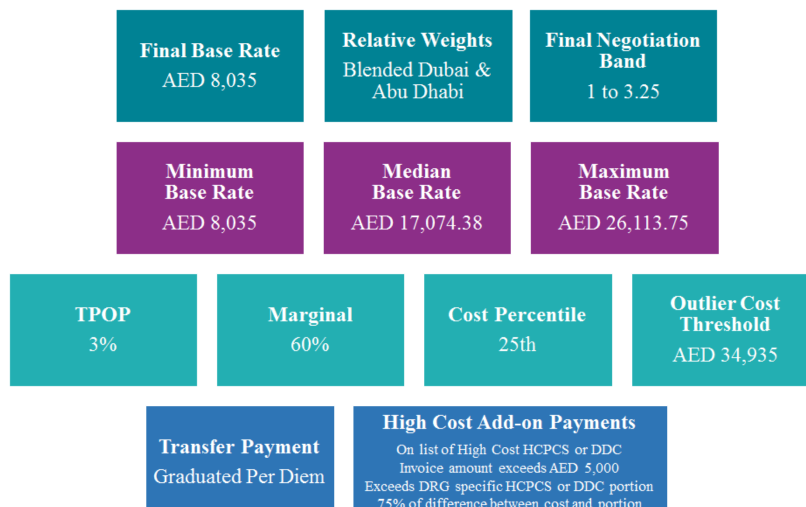
What is a High Cost Consumable and Drug Add-On Payment?

This is an add-on payment that provides risk sharing of very costly consumables and drugs that may not be fully compensated by the DRG payment. Calculated using a percentage of the difference between the consumable or drug documented and invoiced cost to the hospital and the drug or consumable portion of the DRG standard payment.

Are surgical kits eligible for high cost add-on payments?
Individual items in surgical kits will need to be separated and each individual item will need to meet the add-on payment criterion in order to be eligible for additional payments.

Can hospitals apply mark-ups on price of consumables and drugs for high cost add-on payments?
Hospital mark ups are not permitted when submitting claims with add-on payments. Hospitals are requested to submit the invoice directly from the supplier.

How does the Dubai DRG payment parameters look like?



What was the data used in the calculation of DRG payment parameter for full implementation?

Dubai claims data from July 2015 through December 2017, from the eClaimLink system.
Inpatient claims data was identified as:

- Encounter Type 3 Inpatient Bed + No Emergency Room
- Encounter Type 4 Inpatient Bed + Emergency Room

where the length of stay (LOS) is greater than 0 or where LOS is 0 and the patient is discharged deceased.

What is budget neutrality?

Budget neutrality means that, holding the number of admissions, casemix, and other factors constant, hospitals can expect to be paid the same under DRG payment as fee for service payment.

What is an IR-DRG?

IR-DRG stands for International Refined - Disease Related Groups is a classification system with:

- 23 Major Diagnostic Categories (MDCs)
- 700+ DRGs with medical and surgical subtypes
- 3 Severity of Illness (SOI) levels for each DRG families depending on secondary diagnoses:
    - w/o CC (Co-morbidity & complications)
    - w/CC
    - w/MCC (major co-morbidity & complications)

What is an IR-DRG grouper?

An IR-DRG grouper is a software with pre-defined algorithms that classifies patients into different categories based on their condition/diagnosis, treatment modalities, age and sex.

Why did DHA adopt the IR-DRGs?

DHA adopted the IR-DRGs because:

- It is compatible to Dubai's existing medical coding practice (that is, ICD-10-CM and CPT classification);
- It is internationally recognized
- DRG systems are expensive to develop from scratch

What are Major Diagnostic Categories (MDCs)?

MDCs are formed by dividing all possible principal diagnoses (from ICD-10-CM) into 23 mutually exclusive diagnosis areas. The diagnoses in each MDC correspond to a single organ system or cause and, in general, are associated with a particular medical specialty.

What are Severity of Illness (SOI) levels in a DRG?

An IR-DRG is subdivided into three severity of illness subclasses based on the secondary diagnosis. Each and all secondary diagnoses have pre-defined severity levels. For example:

Severity Level	Description	Secondary Diagnosis Example
1	Minor / Without CC*	Hypertrophy of kidney
2	Moderate / With CC*	Chronic renal failure
3	Major / With MCC**	Acute renal failure

*Complications and Co-morbidities

**Major Complications and Co-morbidities

Why is medical coding important for DRGs?

The accuracy, completeness and specificity of medical coding will determine the assignment of DRGs. Capturing every legitimate diagnosis and procedure maximizes the accuracy of DRG assignment and subsequently claim reimbursement.

What are the coding classifications deployed for DRGs?

For reporting of diagnoses and procedures, DHA has adopted the 2018 versions of ICD-10-CM and CPT code sets respectively.

What is ICD-10-CM?

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), for medical coding and reporting in the United States. ICD-10-CM is a statistical classification system that arranges diseases and injuries into groups according to predetermined criteria. The ICD-10-CM system is used for billing in both inpatient and outpatient settings.

What is CPT?

The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel. CPT refers to a set of medical codes used by physicians, allied health professionals, non-physician practitioners, hospitals, outpatient facilities, and laboratories to describe the procedures and services they perform.

Is there any medical coding guidelines or standards deployed?

The Dubai Medical Coding Manual was developed by the Dubai Medical Coding Task Force under the direction of DHA to standardized medical coding and adjudication practices in Dubai.

What is principal diagnosis?

The Principal Diagnosis is the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care. The term after study means evaluation of findings to establish a condition, for example an x-ray will establish a fracture.

What is secondary diagnoses?

Secondary Diagnoses are all conditions that co-exist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode and which have no bearing on the current hospital stay are to be excluded.

What is principal procedure?

The following instructions should be applied in the selection of principal procedure and clarification on the importance of the relation to the principal diagnosis when more than one procedure is performed:

- Procedure performed for definitive treatment of both principal diagnosis and secondary diagnosis. Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.
- Procedure performed for definitive treatment and diagnostic procedures performed for both principal diagnosis and secondary diagnosis. Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.
- A diagnostic procedure was performed for the principal diagnosis and a procedure is performed for definitive treatment of a secondary diagnosis. Sequence diagnostic procedure as principal procedure, since the procedure most related to the principal diagnosis takes precedence.
- No procedures performed that are related to principal diagnosis; procedures performed for definitive treatment and diagnostic procedures were performed for secondary diagnosis. Sequence procedure performed for definitive treatment of secondary diagnosis as principal procedure, since there are no procedures (definitive or non-definitive treatment) related to principal diagnosis

What is principal procedure?

All other significant procedures are to be reported as secondary procedures. A significant procedure is one that:

- Is surgical in nature
- Carries a procedural risk
- Carries an anesthetic risk
- Requires specialized training

What is Present on Admission (POA) indicator?

Present on admission is defined as present at the time the order for inpatient admission occurs - conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
POA indicator is assigned to principal and secondary diagnoses and the external cause of injury codes.

Are Hospitals required to submit codes for consumables, drugs and other services for inpatient claims?

Hospitals will be required to continue submitting consumable codes (HCPCS Level II), drug codes (DDC) and service codes (DSL) for inpatient claims.

What is HCPCS Level II?

Healthcare Common Procedure Coding System (HCPCS) is a standardized code system necessary for medical providers to submit healthcare claims to Medicare and other health insurances in a consistent and orderly manner. HCPCS comprises two medical code sets, HCPCS Level I and HCPCS Level II. HCPCS Level II codes are utilized for drugs, supplies, durable medical equipment, and for filling in gaps within the CPT coding system.

What is DDC?

DDC stands for Dubai Drug Codes and refers to DHA approved drugs available in Dubai Market.

What is DSL?

DSL stands for Dubai Service List and refers to services otherwise not listed in the CPT classification but are required for reporting in claim submission.

Are HCPCS Level II, DDC and DSL codes important for DRGs?

The calculation of DRG payment parameters depends on retrospective HCPCS Level II, DDC and DSL codes that were reported and related payments.