PUBLIC HEARING

before

ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

on

THE IMPACT OF THE DRG REIMBURSEMENT SYSTEM

June 5, 1985
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George J. Otlowski, Chairman

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Corrections,
Health and Human Services

* * * * * * * * *

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

* * * * * * * * *

sk: 1-40

ASSEMBLYMAN GEORGE J. OTLOWSKI (Chairman): Can we come to order, please?

First of all, I am sorry but today is just a bad day and I am running late consistently. It is great to be consistent, but not great for you. In any event, just at the outset, I am going to start the hearing but I may have to recess for about 20 minutes. But we are going to do everything that we possibly can before I call the recess.

This hearing today is primarily related, and is a continuance of our Diagnosis Related Group (DRG) hearings that we have held so far. As a matter of fact, the purpose of this hearing is to consider the impact that the DRG hospital reimbursement system has had on the provision of psychiatric care in general hospitals in New Jersey. The committee is especially concerned about reports that the DRG system has made it impossible for general community hospitals to treat patients adequately within their psychiatric units without losing money.

If these reports are accurate, we would have a situation which would jeopardize the future of psychiatric care in these hospitals by undermining their ability to offer these services within the patient's own community, and to provide the continuity of care and treatment in a compassionate and humane manner.

This issue was first brought to the committee's attention at our public hearing on the Medicare waiver for the New Jersey DRG system last December. This hearing today has been called to focus on this particular aspect of the DRG system in general detail.

The committee hopes that the testimony presented today will provide a better perspective on the problems involved in this important policy area and help us to better see all of the dimensions of the subject. Then again, the things that I usually ask -- if you have written testimony, we want it submitted in sufficient number of copies, and then we impose the injunction that you do not read that testimony that you submit to us, but that you just summarize it when you are testifying, because we will have the written testimony as part of the record, in addition to your extemporaneous remarks.

So, with that we are ready to start, and we are going to call on Dr. Levon Boyajian...He must be a cousin to Chuck Haytaian.

DR. LEVON BOYAJIAN: Yes, we are all cousins.

ASSEMBLYMAN OTLOWSKI: You are all cousins. Doctor, you want to come up here, please? Will you take a seat?

Doctor, will you give us your name for the record, and the organization that you represent, please?

DR. BOYAJIAN: Yes, my name is Levon Boyajian. I am here as a representative of the New Jersey Psychiatric Association.

I am also Chairman of the Department of Psychiatry at St. Joseph's Hospital in Paterson, New Jersey. I have an outline here of what we will be covering --

ASSEMBLYMAN OTLOWSKI: Only one copy?

DR. BOYAJIAN: No, this is not the testimony, it is an outline, in case you want to --

ASSEMBLYMAN OTLOWSKI: How about your testimony?

DR. BOYAJIAN: I will be giving it now. It is not written out.

ASSEMBLYMAN OTLOWSKI: Do you have copies of your testimony?

DR. BOYAJIAN: No. That is what I am saying -- that is an outline, if you want to attach it. It has the major points.

ASSEMBLYMAN OTLOWSKI: All right.

DR. BOYAJIAN: All right? I would like to first start out by indicating that the DRGs initially were designed as a classification system, and not meant to be a reimbursement mechanism. The fact that it has been used that way subsequently makes considerable difficulties, and unfortunately, has been picked up almost in its entirety after some revisions by the State of New Jersey, and put into effect for psychiatry.

ASSEMBLYMAN OTLOWSKI: Doctor, when you started -- forgive me, did you mention the organization that you represent?

DR. BOYAJIAN: Yes, the New Jersey Psychiatric Association.

ASSEMBLYMAN OTLOWSKI: Oh, good, thank you.

DR. BOYAJIAN: It is a chapter of the American Psychiatric Association.

The system originally was dependent upon a survey, primarily of New Jersey hospital records -- about 700,000 records. As it was first used, it was found that there were considerable difficulties with

it, and that it did not meet the criteria for a system that would use a DRG base.

That, fundamentally, was assuming that you could substitute the length of stay of a patient in a hospital as a guideline of the consumption of resources; and by doing that kind of an equation, you would be able to determine what amount of effort and resource was needed to take care of a patient.

The statistics that came out of the first group of DRGs, which was much smaller than the 467 we have now, indicated that they did not fit, and it was expanded. The expanded system was adopted by New Jersey in 1978, in the legislation S-446 that also brought in the whole issue of compensation for indigent care.

At the time, several important things were included in that piece of legislation. One was that the law extended the State's authority to all payers. The cost of uncompensated care was spread amongst all payers; and the hospital rate-setting commission was established to approve or adjust all the hospital rates. With it went the 467 DRGs, only nine of which applied to psychiatry.

One of the other things that was very important in this business was that there was no inclusion of private psychiatric hospitals into this system, so that only the general psychiatry hospitals had to --

ASSEMBLYMAN OTLOWSKI: Doctor, are you saying that psychiatry was not included at all in that system?

DR. BOYAJIAN: No, the private psychiatry was not included.

ASSEMBLYMAN OTLOWSKI: Private -- oh, private psychiatry.

DR. BOYAJIAN: Yes, in other words, the psychiatric units in general hospitals were brought under the system, but private hospitals were excluded.

ASSEMBLYMAN OTLOWSKI: Private hospitals.

DR. BOYAJIAN: Private hospitals, and specialty hospitals. Some of the State hospitals were included, and some of the county hospitals; but the general hospitals had to be included.

In 1980, the first year of the experiment, 26 hospitals were included. By 1982, I think most of the hospitals had come in. In 1985,

now, there are 126 hospitals in this state that are operating on the DRG system; however, only 44 of those have separate psychiatric units. That is an important piece of information, because the impact on the psychiatric units in general hospitals is different from psychiatric patients being taken care of in general hospitals that do not have a psychiatric unit. Other people will speak to that.

The issue in terms of New Jersey is that experience has shown, I think both in New Jersey and this was shown early on when the Hospital Association held seminars back in the early 1980s about the DRGs --It was demonstrated by some researchers that the requirement standard distribution, bell-shaped curve, for the length of stay of patients with any given DRG would have to be met for the system to be effective, just did not pertain to psychiatry. If anything, the curves were flat, bi-modal, and they were not the standard distribution curve.

Unfortunately, the Commissioner of Health was quite upset with this piece of information, and challenged its validity in a rather vociferous manner. But the information has held up and the additional studies done at the Federal level by NIMH (National Institute of Mental Health) have also indicated that the DRGs do not meet the criteria necessary for the system to be applicable as a reimbursement mechanism. The curves do not meet the requirements; as a matter of fact, some studies were done to see if they could improve the DRG system by coming up with some possible alternate groupings of the DRGs in order to make it work, and even with the alternate groupings, they have found that the variation in the length of stay cannot be explained by the variation in the DRG and some of the factors that have been included. At this point all indications are that about 80% of patients are on the DRG system, the variation of their length of stay from what would be a State standard or a Federal standard on the basis of a standard distribution curve do not apply.

This is a very important thing, because early on, there were some objections to this, at least in New Jersey. The State Psychiatric Society did try to work with the Health Department. A committee was formed at that time to try to deal with some of the theoretical problems that were operative with the system; however, only one or two

meetings were held, and that committee kind of fell apart and nothing much was done about it.

Subsequently, as I mentioned, the Hospital Association had a seminar in which the evidence was presented; and then finally, with the Federal system going into effect, as a piece of background, the Federal government at least paid attention to the psychiatric Association and put off inclusion of psychiatric diagnoses in the DRG for two years. This gives the psychiatric community the opportunity to look into the situation and possibly do further research to come up with either some alternate systems, or alternate systems that would, at least, meet the theoretical guidelines for a DRG system being a representation of cost consumption, resource consumption, a payment system that would project, prospectively, what the care of the patient is all about.

This has not happened. All of these statistics at this point indicate that the DRGs as they are listed for psychiatry do not work; alternate systems even with factors that are additional do not work; and that the suggestions will probably be forthcoming from the Psychiatric Association that the DRGs not be used, and that some other system can be worked out, even on a per diem basis, that would help pay for psychiatric care on a prospective payment system. Although they have been working on alternate DRG combinations, indications are that, at least with the information available now, that system will not work. And that is with a couple of million cases, I think, that they have been reviewing.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me.

DR. BOYAJIAN: Surely.

ASSEMBLYMAN OTLOWSKI: I am going to have to recess for about 15 minutes. I am going to ask all of you to be patient with me, and to please do me this special favor. Just for 15 minutes, let me go and I will be right back, okay? Thank you. Just stay right where you are.

Recess

ASSEMBLYMAN OTLOWSKI: Doctor, can we resume where we left off please? Good. And thank you for being so patient.

DR. BOYAJIAN: Not at all.

I just have one or two additional comments to make, and then I will be through. I just wanted to mention something which I had not said earlier on. The S-446 legislation, which was passed back in 1978, I do not think mandated the DRG. The DRG is a piece of business that the Health Department included as the mechanism for implementing the indigent care, and the two are tied together by the Health Department. It is clear that you could pay for indigent care, I think, with some other payment mechanism, if necessary.

The other thing is that when the Feds finally did put in Medicare, the New Jersey experiment which is what this was supposed to be, had been in effect for three or four years, and it was clear to the Feds at that point that the methodology for DRGs for psychiatry was not adequate. They did not include psychiatry in their initial batch, and they are still in the process of considering with the APA other possible ways of dealing with it.

I think with that comment I would like to stop, because others will be indicating at least that -- Yes?

ASSEMBLYMAN OTLOWSKI: Doctor, is anybody speaking officially for the New Jersey Psychiatric Association?

DR. BOYAJIAN: Yes, I am.

ASSEMBLYMAN OTLOWSKI: You are speaking for them. Let me ask you this, then: Have you been in touch with anybody in the Federal government to determine what position the Federal government is going to take on this, in view of the fact that what they have done is just given us a temporary waiver on the present coverage that we are having with the hospitals -- you are aware of that, aren't you?

DR. BOYAJIAN: Yes, I am.

ASSEMBLYMAN OTLOWSKI: Has your association been talking to anybody in the Federal government about what the long-range view of the Federal government is on this particular problem as it affects the psychiatrist?

DR. BOYAJIAN: Well, in terms of the psychiatrist, the American Psychiatric Association specifically has a task force on prospective payment which has been investigating this, and has been in

the process of trying to get the Feds to put off implementing that piece for psychiatry. The final outcome of how the Federal government will react to the proposals will be coming up shortly, in the next couple of months. I do not know about them yet. But the American Psychiatric Association is very active with the Federal government.

ASSEMBLYMAN OTLOWSKI: Doctor, let's just summarize now. You are saying that the present system of DRG is not working at all as it is related to psychiatry? Am I correct in that? [affirmative response] Or did I go too far?

DR. BOYAJIAN: No, that is correct. It does not meet the theoretical requirements for a prospective payment based on a DRG. That is correct.

ASSEMBLYMAN OTLOWSKI: So that the only thing that it does at the present time is what?

DR. BOYAJIAN: Well, right now the only thing that it seems to be doing is devastating the psychiatric units in general hospitals.

ASSEMBLYMAN OTLOWSKI: Because of the fact of complete lack of coverage, is that what you are saying?

DR. BOYAJIAN: No, because the coverage is grossly inadequate and does not meet a system that would make it reasonable.

ASSEMBLYMAN OTLOWSKI: But Doctor, is there some coverage at the present time?

DR. BOYAJIAN: Yes.

ASSEMBLYMAN OTLOWSKI: And that coverage is what?

DR. BOYAJIAN: There are nine DRGs in psychiatry --

ASSEMBLYMAN OTLOWSKI: They are what?

DR. BOYAJIAN: You want the names? Somebody else is going to go through all that.

ASSEMBLYMAN OTLOWSKI: All right, I just want to make sure that we get it.

DR. BOYAJIAN: Oh, you are going to get it all. There are other people from the Society, and I wanted to stop there.

ASSEMBLYMAN OTLOWSKI: Good, Doctor. Thank you very much.

DR. BOYAJIAN: Thank you.

ASSEMBLYMAN OTLOWSKI: Dr. Nicholas Videtti, please?

Doctor, let us have your name, and if you are representing anyone, will you put that in the record too, please?

DR. NICHOLAS F. VIDETTI: My name is Nicholas F. Videtti. I am representing the New Jersey Psychiatric Association. I am General Hospital Committee Chairman; I am also a counselor in the New Jersey Psychiatric Association.

I am Chief of Psychiatry at Holy Name Hospital in Teaneck, and attending psychiatrist at Valley Hospital in Ridgewood, and in private practice in psychiatry. I represent the New Jersey Psychiatric Association, and in continuation of Dr. Boyajian's paper, essentially will be followed by Dr. Rubin and Dr. Nadel.

One of the issues that Dr. Boyajian made when he spoke about the DRGs was the nine of them for psychiatry. The nine DRGs for psychiatry are numbered from 424 through 432.

The first one covers mental disorders that also include any operating room procedure. The second group, 425, is acute and adjustment reactions and/or psycho-social neurosis. Four twenty-six is neurosis with principle diagnosis of depressive neurosis. Four twenty-seven is neurosis without principle diagnosis of depressive neurosis. Four twenty-eight is disorder of personality and/or impulse control, and 429, organic disturbances and/or mental retardation.

Four-thirty is psychosis medical, and this is a big one; 431 is childhood disorders, and the last of the psychiatric diagnosis, number 432, is other diagnoses of mental disorder.

ASSEMBLYMAN OTLOWSKI: Why don't we have a copy of that?

DR. VIDETTI: You can have it.

ASSEMBLYMAN OTLOWSKI: No, no, that is the only copy you have, isn't it?

DR. VIDETTI: It is the only copy I have, but every DRG list, lists these.

ASSEMBLYMAN OTLOWSKI: Would you let me have your copy?

DR. VIDETTI: Certainly, be glad to.

ASSEMBLYMAN OTLOWSKI: Doctor, would you just hold on a minute? I just want to get my bearings here. [brief pause]

DR. VIDETTI: Of those nine groupings, there are only two that really include 90% of our psychiatric population in our general hospitals. Four-thirty, which is called medical psychosis -- that has in itself, about 90% of our population. The 426, which is depression neurosis, gets the other grouping.

In the last year and a half at our hospital, which is pretty typical, of the 600 admissions we had to the psychiatric unit, almost 500 of them came under the heading of 430, and we had approximately 68 in the grouping 426. All the other eight had very few psychiatric admissions. In childhood, there are very few in general hospitals, since they do not admit children.

One of our problems with DRGs in psychiatry -- and you had asked Dr. Boyajian if the Federal government was doing something -- The Federal government has, from the outset, exempted all psychiatric units, in part because they felt there was not enough information to determine a prepayment for an illness, because the diagnosis in itself really does not tell you how sick someone is, or how much of the resources they are going to utilize. For instance, you take a lovely woman, 65 years old, who comes in depressed. Now, when she comes into the hospital depressed, she may not have eaten for two or three weeks before she came in, so any other illness is going to be accentuated, even if she is not sick enough to be admitted, let's say, for diabetes out of control. Because she has not been eating, she has lost weight, she is thin, she may be malnourished, she may be dehydrated, she may need a lot of medical help. But the reason she is in the hospital is depression.

Another person may come in very healthy, and ready to tear the walls down; also depressed, but agitated. That person has to be put under constant watch. Other patients are going to come in needing medication, but then after we give them medication we find out that because of the side effects of the medicine, they can not be treated. The bottom line is that some of these patients are going to need 30, 35 days before their depression is taken care of, because you may have to change treatment. You may have gone from treating with medication and reaching a point where the patient is not able to take medicine; or deciding that shock treatment is the way to treat this person.

By saying "depression," it is a beautiful word and it is terrible to have, but you can not make a payment by using the name, because you do not know how sick the person is -- whether this is their first episode of depression, what their family support system is when the leave the hospital. If there is no one there to care for them, if they are going to go back out in the street, if they have no money to buy medication to keep them on the antidepressant to keep them from being depressed again. We really run into a big problem with this.

It is like owning an automobile agency; and you have to accept every car that comes in; and you will be given a fixed amount of money to take care of the cars. Those cars may only need an oil change, or they may need a total transmission workover. And you find, after a while, that you are only getting transmission work and there is no payment that is large enough to cover this on a constant basis.

This is where we have been running into our problem. DRG gives the hospital a fixed amount of money to treat a patient. If it uses up that money --

ASSEMBLYMAN OTLOWSKI: Doctor, how would you change this? What are you suggesting -- how would you change it?

DR. VIDETTI: Our fourth speaker, Dr. Nadel, has a whole list of changes. Right off the bat, I would say that a way to change it would be to alleviate the pressure we are under right now. For example, as I started, our hospital gets approximately $3,600 to treat someone under this category, 430. Three thousand, six hundred. If we were just paying for the hospital room, that would pay for about 12 days, the hospital and medication. Dr. Rubin, who follows me, will talk about the amount of time it takes medication to work, but, if that person needs more X-rays, if they have to have intravenous because they are dehydrated, if they are coming in with another illness that needs antibiotics -- if they need other medical, we have used up that money even before you are up to the fifth or sixth day. This puts pressure on the hospital, and while they want to help and do not want to distinguish between giving good care and throwing patients out, there is a pressure. The pressure may come in very subtle form -- the hospital saying, "You know, you have had 60 admissions this year, and

we have lost $60,000." They are not telling you not to admit patients, but then when you do ask for extra help to take care of the person who may be suicidal, the hospitals really strain to get someone to fill in that spot because, they claim, they do not have money, they are losing money. This is something the Hospital Association will work on, but it is something that we, as psychiatrists who are trying to treat a patient, have to deal with.

The other issue that will come up later on today will be the fact that not every hospital is under this strain. In the creating of hospitals that are free of DRGs, where they do not have a limit and where they will receive payment by the day under a shared mechanism, they can collect up to $20,000 for the same diagnosis, for the same patient, for the same number of days. But the general hospitals are immediately restricted to the $3,600, and that is a problem. It is an inequity, an unfairness that definitely has to be addressed, since it only benefits a few people in the State, and the majority of the people in the State are suffering because of this inequity.

Which leads to another problem that is -- yes?

ASSEMBLYMAN OTLOWSKI: How are patients suffering as a result of what you call the inadequacy of the system? How do patients suffer?

DR. VIDETTI: Patients are suffering because there is a pressure to get the patients out as soon as they are well. Now, we do not only have a DRG which gives us money up front for --

ASSEMBLYMAN OTLOWSKI: You don't mean that. You don't mean, to get the patient out as soon as he is well.

DR. VIDETTI: No. Not "well" well, but the minute the patient can carry on. Unfortunately, with depression, the minute the patient starts to feel better, it is also the most difficult time in that suicides, when they do happen, happen not at the depth of the depression but as the patient starts to feel a little bit better. There is definitely a three or four day lag between the patient starting to feel better and the patient's awareness that he is better.

So, the patients are suffering in the sense that we feel pressure to get these patients out earlier. It is no fun to be in the hospital where you feel you are losing money for the administration.

ASSEMBLYMAN OTLOWSKI: Doctor, I think, let's just hear from Dr. Kenneth Rubin now to supplement your testimony. Doctor, thank you very much.

Dr. Kenneth Rubin, please.

You know, I was always under the impression that psychiatrists were frustrated novel writers, yet everybody is just submitting an outline. I was completely wrong.

Yes, Doctor?

DR. KENNETH J. RUBIN: I am Dr. Kenneth J. Rubin, representing the New Jersey Psychiatric Association. I am Vice President of Internal Affairs, and am also a member of the General Hospital and Psychiatry Committee of the New Jersey Psychiatric Association.

I am an attending physician in the Department of Psychiatry at Monmouth Medical Center in Long Branch, the Chairman of the Quality Assurance Committee in the Department of Psychiatry in the Monmouth Medical Center, and I have a private practice in Long Branch.

In my testimony, I would like to inform the committee of some of the issues regarding the DRG system in New Jersey, and psychiatric services as well as some of the inadequacies that the DRG system has helped to develop and foster.

Number one, the clinical treatment of the psychiatric patients in the hospitals often compromise for the short length of stay which is required by the DRG. For example, as stated by Dr. Vedetti, there is the treatment of depression -- the many different categories of depression which are all lumped into one DRG, number 430, specifically.

More specifically, though, the drug treatment of depression is difficult and takes a period of time, and an adequate length of time. A trial of a tricyclic antidepressant takes a minimum of three to four weeks, which is just about the whole length of the DRG and clearly over the median for the DRG for depression.

Also, the use of electroconvulsive therapy for the treatment of depression would make somebody an outlier by the time a patient is worked up, medically clear and the course begun. It also creates the problem of giving somebody a trial of one drug, finding the person

possibly unresponsive to it, then having to switch to another drug or an electroconvulsive treatment as recommended by the American Psychiatric Association. By this point the person is an outlier, and it is a push to have the patient discharged from the hospital.

There are the issues of treating major other illnesses, such as bipolar affective disorder in the manic state. It takes people a considerable amount of time to respond to lithium, as well as a major tranquilizer that might be used. By then they are near the end of the DRG, and there is a push to get these people out before they are adequately treated or before they have an adequate dose of medication, or the symptoms are partly into remission.

Number two, there is also discrimination against the psychiatric patients because comorbid conditions are not reimbursed at all under the DRGs. For example, the psychiatric diagnosis at this point in time as defined by the "APA Diagnostic and Statistic Manual 3," lists five axes, and this is how psychiatrists are supposed to diagnose people.

Axis one is for the major disorders; for example, schizophrenia, other psychoses, depressions, and dementias. Axis two is the personality disorders, which can greatly influence the length of time of the problems that arise with these people. Axis three are the medical conditions which affect the first axis; for example, hypertension, diabetes, congestive heart failure and other medical disorders, all of which can clearly influence the drugs used, the dosage, and the time to treat these people. There are many complicated factors which have to be considered in treating the people in all three categories.

There also is the issue of these patients coming in through the medical service, or through the ICU or CCU after an overdose. These diagnoses and treatments rendered to these patients are not considered in the final diagnosis or reimbursement to the hospital, but they do count toward the time they were in the psychiatric unit.

At this time we are seeing patients that are sicker, older, have more complicated cases, and have many covert conditions which clearly influence the treatment, length of time, and medications. These are not taken into consideration in the psychiatric DRGs at all.

Number three, the State has now mandated that everyone, for a period of time, prevent malpractice, because an inadequate length of stay is not an adequate treatment for a variety of illnesses. For example, in treating depression as stated above, a lot of patients will come in after a suicide attempt and will be psychotically depressed. Clinically, it is known that the time of the greatest risk for someone who has made a suicide attempt, or is severely depressed and would likely make another attempt, is when the patient starts to feel a little bit better.

This is the time the DRGs may push people out by the median. People might just be responding to the medication at the second to third week. We are told to get the patients out of the hospital and continue them outside. This when these people are most at risk to have a suicide attempt, and it is not unlikely that we will have more suicide attempts as these patients are discharged prematurely from the hospital.

There is also a question of treating patients with psychosis and agitation. Just as soon as the psychosis starts to resolve, and some of the primary symptoms are lessened, there is a push to get the patients out of the hospital. They are not improved enough or stable enough, and there is a question of discharging a lot of people in a more tenuous state, when they are barely being held together; whereas if we had more time to treat these patients, they would be in a better shape, and there would probably be less chance of something happening to them or other complications for readmissions in a short time.

Therefore, the DRGs are based on the category of diagnoses, but they are not indicative of any level of intensity of treatment that is required, nor the allocation of resources that are needed. Reimbursement is based on a diagnosis and as we are aware, diagnosis is just a classification of a patient or a disorder. There are many other factors that go into what this person's problems will be and how to treat them. For example, a schizophrenic patient who is a high-functioning person having had his first psychotic episode might reconstitute in a short period of time. These people might also have a good family and good support in the community, but for someone who has

been ill for a long period of time, without a good family support system, and who has also been in a state hospital system numerous times, it is going to take a long period of time, and more community resources, to get him well.

Our Quality Assurance Committee at Monmouth Medical Center did a study on the length of stay of bipolar affective disorder patients for the first six months of 1984. What we did was stage the patients into stages 1, 2, and 3. This was based upon "Clinical Criteria for DRG Staging" by Joseph Ganella. The DRG for bipolar affective disorder is three to 33 days. We found that stage 1 patients who are acutely psychotic and not emotionally or severely agitated, have an average length of stay of 15.25 days. Stage 2 patients who were more severely disturbed or disorganized, had an average length of stay of 25 days. The stage 3 -- the more seriously ill bipolar patients -- the average length of stay was 36.5. Therefore, the last stage, the most severely ill people, were clinical outliers of the DRG, and most of the stage 2 patients were past the median for the DRG.

It is clear that the average length of stay for the psychiatric illness will vary according to the stage of the illness, with the more severe stage of the illness requiring more time in a hospital. This is true for bipolar affective disorders, schizophrenia, schizo-affective disorders, etc. These factors have to be built into the system and taken into consideration: how much treatment is needed, the degree of the compensation of the illness, the chronicity, the community resources necessary, the community help that is available, and the hospital resources including nurse's time, doctor's time, and all ancillary care in the hospital.

As far as DRGs as a reimbursement mechanism, it has been disguised by using medical terminology and lumping all the psychiatric diagnosis into a few DRGs. It has been shown that you cannot refuse the diagnosis, as stated above, as a way to reimburse. We find that a lot of the psychiatric diagnosis are requiring a longer length of stay, and mostly all of them are clinical outliers. Initially, the State Department of Health was paying for these on the cost basis, but in 1984, the State Department of Health did away with the clinical

outliers, basically as a way to save money, not because they were clinically inappropriate, which they clearly are.

You can see why, then, the psychiatric conditions require more time to treat than is being allocated. Also, the assumption of the DRGs as a statistical model for reimbursement as a psychiatric diagnosis and length of stay approximated a normal curve. However, there have been studies shown to the Department of Health that the length of stay for psychiatric diagnosis clearly did not approach a normal curve. The distribution for psychiatric diagnosis were rectangular, with long tails, long beginnings, and bimodal.

Therefore, diagnosing these as fitting into a normal curve when they clearly do not, makes it difficult, if not impossible, to work under the system.

One of the other problems with the DRGs for psychiatry is that, unlike all medical and surgical illnesses, not all the hospitals providing care for the mentally ill in the State of New Jersey are included. All hospitals providing that care are included in the DRG. For example, no State hospitals are included; only one county hospital is included; some of the free-standing hospitals are not included; and the private, for-profit or not-for-profit psychiatric hospitals are not included.

Therefore, since these hospitals -- specifically, the latter, private hospitals and private free-standing hospitals -- are not included in the DRGs, they do not have the same restrictions and the doctors are not under the same pressure to discharge patients. Therefore, the patients are treated more adequately and more completely.

The patients are now favoring the use of these private, free-standing hospitals and not the general hospital units. That is creating a major problem for the general hospitals in the State.

These are some of the inadequacies that I would like to point out to the committee, and I appreciate the opportunity to testify here. Dr. Nadel will outline some of the Association's specific solutions.

ASSEMBLYMAN OTLOWSKI: Doctor, let me ask you this question. Are you saying that because of the present DRG system, psychiatric patients are not getting proper and adequate care -- is that what you are saying?

DR. RUBIN: They are not getting as adequate care as they can in the general hospitals; or as detailed or as complete as they could or should have.

ASSEMBLYMAN OTLOWSKI: Are you saying that under the present system of DRG, that the same kind of a yardstick that is supplied to physical illnesses does not apply to these illnesses? Are you saying that?

DR. RUBIN: Yes, essentially.

ASSEMBLYMAN OTLOWSKI: As a result of saying that, are you also saying the treatment is far from being adequate?

DR. RUBIN: Well, at the time for the treatment, a lot of the patients in other medical illnesses can respond in a shorter period of time. Antibiotics ordinarily can take effect in 10 to 14 days, and you might cure an infection or clear up congestive heart failure, whereas the treatments that we render do take more time.

ASSEMBLYMAN OTLOWSKI: In the course of this testimony today, will there be suggestions of how this can be overcome? Will there be suggestions of a better approach?

DR. RUBIN: Yes, that is Dr. Nadel's testimony.

ASSEMBLYMAN OTLOWSKI: Okay; all right. Thank you very much, Doctor.

Dr. Nadel, please? Doctor, do you have written testimony?

DR. WILLIAM NADEL: I do have an outline of my written testimony like the other psychiatrists of this era; we are not novelists...

ASSEMBLYMAN OTLOWSKI: Everyone from the Chairman down is consistent this morning. This is an outline? How many copies do you have here?

DR. NADEL: Eight.

ASSEMBLYMAN OTLOWSKI: Doctor, will you give us your name and who you are representing?

DR. NADEL: Yes. I am Dr. William Nadel. I am representing

the New Jersey Psychiatric Association as a member of the General Hospital Committe. I am Chief of Psychiatry of Muhlenberg Hospital in Plainfield, and in private practice in Union County.

I was chairman of the New Jersey Hospital Association's New Jersey Committee when, in 1979 and 1980, we ran two statewide seminars on organizing and the financing of mental health services in New Jersey hospitals. I formerly served as Deputy Commissioner of Mental Health for the City of New York.

ASSEMBLYMAN OTLOWSKI: Doctor, from the testimony that took place up until this point, what is emerging is the fact that psychiatry as a method of treating patients that were mentally ill is not fitting under this umbrella of the DRG, for the kind of care and treatment that patients would be entitled to generally, under the DRG. Is that correct?

DR. NADEL: Yes, that is correct, sir.

ASSEMBLYMAN OTLOWSKI: How could that be improved; how could that umbrella be extended to cover those patients?

DR. NADEL: Well, as my outline indicates, the present system discriminates against patients with a primary diagnosis of a mental illness, and is not only inequitable, but is probably unconstitutional in this discrimination.

ASSEMBLYMAN OTLOWSKI: Doctor, we have got too many lawyers here this morning already...

DR. NADEL: I am not a lawyer, sir. My mother was, but I am not.

ASSEMBLYMAN OTLOWSKI: Well, it is showing. (Laughter)

Now Doctor, I want to make the record clear; I am trying to be helpful here.

DR. NADEL: Yes, I understand, sir.

ASSEMBLYMAN OTLOWSKI: What I would want to see at this point, extemporaneously from you and based upon your experience -- What do you see as a better aproach to this thing? Off the cuff.

DR. NADEL: Off the cuff, the best way, or a better way to do things in terms of rendering care to mentally ill patients is to exclude the psychiatric diagnoses and the care rendered to psychiatric

patients in general hospital psychiatry units until an adequate methodology can be developed which deals with these diagnoses and the treatment.

The Federal government is taking that position. They excluded care rendered in designated psychiatric units in general hospitals from their Medicare DRG reimbursement system because they realized, in 1983 and 1984, that there was inadequate methodology to include psychiatric diagnoses and the care for those kinds of patients —

ASSEMBLYMAN OTLOWSKI: What is the Federal government doing about that now?

DR. NADEL: They have excluded that from the -- Medicare excludes psychiatric diagnoses, or care of the psychiatric patients rendered in general hospital psychiatric units from their DRG system. In other words, the DRG Medicare patients are not reimbursed --

ASSEMBLYMAN OTLOWSKI: Because they could not come up with a yardstick?

DR. NADEL: Because they felt that the yardstick that had been come up with so far, as in New Jersey and a few other states where HCFA [Health Care Financing Administration] had started experiments, as they were viewed from Washington, in reimbursement --

ASSEMBLYMAN OTLOWSKI: Based upon your experience in New Jersey, based upon your experience as a practicing psychiatrist in hospitals, what would you do to change this system so that it would be workable, so that it would cover psychiatry at least somewhat adequately, and give the patient better care and better treatment? What would you do?

DR. NADEL: You are talking, really, what I would call a second option, a less equitable solution than excluding the psychiatric patients with psychiatric diagnoses from the DRG reimbursement system. At present a less favorable one to them, and less fair, would be to modify the DRG system in several important ways, so that at least there is a more equitable treatment of people with those --

ASSEMBLYMAN OTLOWSKI: Modify it in several ways -- One?

DR. NADEL: One, modification should include reimbursement acknowledgement of comorbid conditions, both medical and psychiatric,

as is the case for individuals with medical diagnoses or surgical diagnoses, so that there would be an allowance for the complications that have been alluded to in some of the prior testimony; and the fact that having two or three conditions complicates the care and has been demonstrated to lengthen the time needed to get a person functioning and well to resume their life in the community.

ASSEMBLYMAN OTLOWSKI: Two?

DR. NADEL: Two, reimbursement should carve out the stay on ICUs in general hospital telemetry units, or cardiac care units, for those patients who so severely injure themselves with suicide attempts, for example, that they require a few days in the ICU to recover from their lacerations, to have their surgery, to have blood replacement, and then go to a psychiatric unit for psychiatric treatment.

It should also carve out those people who take overdoses and may spend up to 3-5 days in a cardiac care unit, having the effects of the overdose -- the arrythmias, etc. -- taken care of. Because what happens now is, we might get a patient on who spent 3-5 days in the intensive care unit or the coronary care unit, basically just getting stabilized medically, and then they can be transferred to psychiatry with their medical or surgical condition somewhat taken care of, although they will need continuing care. Then, we treat them, but those 3-5 days are counted against the psychiatric diagnosis, and there is no allowance made for psychiatry or for psychiatric diagnosis, or for comorbid conditions, or for the prior length of stay on other units. It is all counted against the psychiatric diagnosis trim points, which are inadequate trim points as has been mentioned before, to treat people given the modern psychiatric techniques that we have and use in our general hospital units.

A third alteration to the reimbursement mechanism would be to take into account the chronicity of illness. Those with chronic illnesses require longer-term treatment to reach the same point of recovery, or a point of recovery when it is really safe for them to leave the hospital, than those individuals with the first episode of an illness.

The present system does not take that into account at all. There is no factor, no reimbursement, for chronicity. But, another factor -- the fourth factor is the number of prior hospitalizations. What we are seeing now is individuals with perhaps not chronic illness, but with multiple hospitalizations, multiple brief hospitalizations, forced by the reimbursement systems during which they are never adequately treated -- they return too quickly to their communities; the psychiatrist may have to re-hospitalize them in two to three weeks or two to three months, whereas a longer stay could have been more definitive treatment and could have obviated the need for multiple readmissions.

Another factor that has to be taken into account and addressed in terms of reimbursement is the duration of hospitalization. In other words, you can have people who are only hospitalized once prior, but they may have been hospitalized for a year. And to expect that that individual is going to have the same length of stay as an individual who is having his first break of schizophrenia, or is having his first psychotic depression, is clinically unsound.

This really points out something I would like to underline. The DRG system, because it has medical diagnoses attached to it, seems to a lot of people to be clinical, or medical. It is not. It is, purely and simply, a reimbursement system. As has been alluded to, what the State Health Department has done in regard to outliers is a good example of that. Formerly, patients stayed longer or were treated as outliers and hospitals were reimbursed on a per-diem basis. The State Health Department has changed that, so that patients who may stay longer and may have their stay validated by the PRO [PRO-Pac, Prospective Payment Assessment Commission], which is outside the control of the hospitals or the particular treating psychiatrist. They may say validly that the person needs to be in the hospital, but the reimbursement for that is a pittance, and does not represent at all what the costs are under the new Health Department methodology. As you may recall when I testified in December, my recommendation at that point was to treat all psychiatric diagnoses as outliers, until the

methodology could be developed in concert with the Health Department to adequately deal with these kinds of diagnoses.

ASSEMBLYMAN OTLOWSKI: That methodology that you are talking about working out with the Health Department -- Who would work that out with the Health Department? Your Association?

DR. NADEL: I think that we certainly should be involved in that. That is really up to the Health Department, and I must say, given the experience in New Jersey with the Health Department, I am not very sanguine. What happened after the DRG experiment was started in 1980, was after the first year's analysis, we ran a seminar when I chaired the Mental Health Committee, which showed that the psychiatric diagnoses did not have the homogeneity needed to fit in a DRG reimbursement system. A committee was formed, and I believe the first meeting was held in May or June of 1981.

ASSEMBLYMAN OTLOWSKI: The committee was formed by whom?

DR. NADEL: By the Health Department to advise them on psychiatric diagnoses, which they had already put into effect over a year before -- sort of a little bit late if you want to get some judicious advice about how to do something.

ASSEMBLYMAN OTLOWSKI: Yes, but what happened with that committee, and as a result of that committee?

DR. NADEL: Well, nothing happened.

ASSEMBLYMAN OTLOWSKI: Nothing?

DR. NADEL: Because after two or three meetings, there were no more meetings. The psychiatrists who did attend said that the Health Department people attending did not seem particularly interested in their point of view, and did not seem really very interested in talking with them any further, and the committee sort of died. No one was notified who was on the committee that it officially ended, it just never met any longer.

ASSEMBLYMAN OTLOWSKI: So that right now, that whole thing was left in the air?

DR. NADEL: That kind of advice was suspended, but the Health Department went on its way to declare the experiment a success without evaluating it and without having any kind of external review, except

for financial review; and whether its financial review is accurate or not is a matter, I guess, for HCFA and the Health Department to decide. Certainly that has been a matter of great debate over the preceding months since last September.

ASSEMBLYMAN OTLOWSKI: What do you suggest that the Health Department do with this? You made six points that you felt the Health Department should consider immediately, to extend the umbrella to give you the kind of coverage —

DR. NADEL: Right. I do have a few more that I would like to mention as well, such as the severity of the functional disability, which is another important factor to take into account.

In other words, schizophrenia is a diagnosis. With medication, that diagnosis may render someone able to function as a doctor, lawyer or Indian chief. That same diagnosis may render a different individual incapable of functioning or of ever being gainfully employed, and of having to be on SSI disability. The degree of functional disability impacts on how long an individual, who may have an illness, needs to be in a hospital in an acute state.

In other words, people with chronic illnesses walk around every day and they have exacerbations. They acutely need to be hospitalized and then they get over those acute hospitalizations, or the need for the acute hospitalization, and go back to their former life. However, if an illness has so devastated an individual that he can not be gainfully employed, can not function with a family, or in a work or school situation, it stands to reason that they are going to require a longer length of stay than an individual who can go back and rejoin his workplace and his family, or go back to school and pick up the pieces of his life.

The last thing I would like to recommend is to account for the severity of psychosocial stressers, and the sufficiency of family and other supports. These latter two are diagnostic entities that modern psychiatric terminology uses. They are in Diagnostic and Statistical Manual Edition Number 3, which has been in effect since 1980 --

ASSEMBLYMAN OTLOWSKI: Doctor, just hold up because I want to keep this in perspective. DRG now provides 400-some situations for coverage; am I correct?

DR. NADEL: That is an interesting point, sir. Yes. There are 467 DRGs. The 383 DRGs, initially --

ASSEMBLYMAN OTLOWSKI: And that is provided now in the DRG system, by law and by regulation, am I correct?

DR. NADEL: By regulation, not by law. The DRG system --

ASSEMBLYMAN OTLOWSKI: By regulation resulting from law.

DR. NADEL: The DRG system was the Health Department's way of providing reimbursement to New Jersey hospitals. It took into account State law S-446 —

ASSEMBLYMAN OTLOWSKI: What would you want this committee and the Legislature to do?

DR. NADEL: I don't know exactly what the purview of the Legislature would be. I think that the Legislature should insist on equitable treatment for patients with mental illness as there is for those with physical illnesses. There is no primafacie case that those with mental illnesses are less deserving of adequate treatment than those with physical illnesses. In fact, all recent legislation and State and national policy stated that those with mental illness deserve adequate treatment. The mentally ill have long been discriminated against. That is one of the reasons that the people who treat the mentally ill, such as psychiatrists, had to stand up and try to be the advocate for the patients, because the patients are embarrassed by their illness and do not speak for themselves.

So, what I would like is for you to insist --

ASSEMBLYMAN OTLOWSKI: You don't know, off the top of your head, how much money is being spent by DRG now annually?

DR. NADEL: I don't, but I could refer to the Governor's report to the President if you would like.

ASSEMBLYMAN OTLOWSKI: You don't know that off the top of your head?

DR. NADEL: No, I am afraid that I don't.

ASSEMBLYMAN OTLOWSKI: Let's save that reference for later.

DR. NADEL: I would like to add, though, that public policy in the State of New Jersey with the Health Department pushing a DRG system on general hospitals and excluding private hospitals, including the for-profit hospitals, is pushing care to be more expensive, because you are taking people out of the hospitals where rates are much lower and putting them in hospitals where rates might be $1,000 per day. And also, as general hospital units become eroded and close, you will be pushing those who cannot afford that, or those whose insurance does not cover that, onto county and State hospitals. So public policy is very misguided in this sense.

That is one large problem. Another is that the Health Department and the Department of Human Services put the general hospital psychiatry units in an impossible position. One department is going one way and the other department is going exactly the opposite way.

ASSEMBLYMAN OTLOWSKI: Doctor, to do the things that you just talked about, that you enumerated -- you are saying basically that --

DR. NADEL: If you could pass a law to get them done, I would be for it.

ASSEMBLYMAN OTLOWSKI: Fine. Let me ask you this question, though. What do you think that would add to the present DRG cost? How much do you think that would add to the cost?

DR. NADEL: I am not sure that there is additional cost. As I said, present public policy is making it more expensive to the State and to insurance companies than a different public policy would be, by influencing people to seek care in private facilities --

ASSEMBLYMAN OTLOWSKI: Doctor, I think that --

DR. NADEL: -- that are more expensive than the general hospitals and are at some distance from them.

ASSEMBLYMAN OTLOWSKI: Doctor, I think that if we are going to ask for an improvement in the service, and we want to do that, one of the things that we will have to show is what kind of an additional cost, if any, that will be? What would it add to the present cost? Can I get those figures in some elementary testimony via a memorandum? Can I get that?

DR. NADEL: I am not sure what question you are asking, sir, because it has been demonstrated that covering psychiatric illness, both outpatient and inpatient, reduces the total cost for insured individuals. In other words, there is a cost savings with a unconstrained psychiatric coverage, after four or five years. This is because unnecessary medical/surgical procedures and hospitalization are avoided.

ASSEMBLYMAN OTLOWSKI: If you would impose these numerical additions that we were talking about, obviously you would increase the cost of care.

DR. NADEL: Impose what numerical additions?

ASSEMBLYMAN OTLOWSKI: Those things that we went over, the 1,2,3,4,5,6.

DR. NADEL: We would be increasing, perhaps, the cost of a given hospitalization. We might well be avoiding multiple hospitalizations. And it is cheaper, on a per diem basis -- and I believe the Health Department and the Hospital Association might back me up on this -- that the most expensive days of hospitalization are the first few days, perhaps the first 3-5 days. And having someone in a hospital from day 10-20 is not as expensive as having them in the hospital from day 1.

ASSEMBLYMAN OTLOWSKI: But how could you spell that out so that it would have some meaning to the record here?

DR. NADEL: Well, I have cited the data and can get the supporting documents that indicate there is a reduction in the general overall cost per person when psychiatric benefits are covered equitably, without prejudice, as any other medical/surgical illness. That I can provide to you; that is a matter of a number of studies.

So far as whether or not the first three or four days of hospitalization are more expensive than days 14-18, that data might be able to be supplied by the Hospital Association or the Health Department which keeps the data on hospital costs.

ASSEMBLYMAN OTLOWSKI: Right.

DR. NADEL: As a psychiatrist, I don't do that.

ASSEMBLYMAN OTLOWSKI: Do you want to continue with your other testimony? I am sorry that I derailed you.

DR. NADEL: I didn't feel that you were derailing me; I felt you were asking me to explicate some points that I was making.

If we can not exempt psychiatric units in general hospitals from the DRG system, which has every prospect of making these units unviable and forcing people to more expensive or publicly supported hospitals, such as county and State hospitals, we are going to be making an advance. In addition to these measures that I have outlined, I think that some specifics that could be done would be a conference committee, if you will, between the Health Department and the Department of Human Services to decide whether they want general hospitals to provide services to the chronically mentally ill or not.

ASSEMBLYMAN OTLOWSKI: That conference committee that you just suggested -- What would be the makeup of that conference committee?

DR. NADEL: I would hope representatives from the New Jersey Psychiatric Association, as well as the Health Department and the Division of Mental Health Services.

ASSEMBLYMAN OTLOWSKI: And who else?

DR. NADEL: And who else...I am not an expert in setting up these kinds of commissions; I think the Mental Health Law Project has one advocacy group. I think the Mental Health Association in New Jersey should be included, because they should see that psychiatric patients are being disadvantaged compared to other patients, or patients with those diagnoses are being disadvantaged. I think this really would be a step, to take up an advocacy position for these individuals who do not very easily or often speak for themselves. That would be something to do aside from redressing the present ills that the DRG system has, and the inequities that are implicit and explicit in it.

ASSEMBLYMAN OTLOWSKI: All right. Doctor, do you think that you have presented your case adequately here?

DR. NADEL: I hope so. You might be a better judge of that than I. I would like to respond to a question you asked one of the earlier psychiatrists that testified, which is, how do patients suffer as a result of this system?

Well, in addition to suffering the out-of-pocket expense of going to a more expensive hospital or going to a public hospital, patients suffer by having their treatment relationship interrupted when they go to a hospital that is located a distance from them and their families. They also suffer from not having the families available to them as they would be in their local general hospitals.

So, there are at least two ways they suffer, in addition to any financial suffering that they might have.

ASSEMBLYMAN OTLOWSKI: Doctor, is there anything else that you want to add?

DR. NADEL: No, thank you.

ASSEMBLYMAN OTLOWSKI: Doctor, thank you very much.

DR. NADEL: Well, I want to thank you very much for the opportunity to testify here before you.

ASSEMBLYMAN OTLOWSKI: You were the guy who brought us here originally, weren't you?

DR. NADEL: You were the person who brought us here.

ASSEMBLYMAN OTLOWSKI: Well, thank you very much.

Can we hear from Faith Goldschmidt, please?

Faith, would you want to hold up for a minute? Let me just push you out for a minute.

Let's get Craig Becker first so we get that hospital point of view first, all right, Faith? And then we will get you back.

CRAIG A. BECKER: Mr. Chairman, I am Craig Becker from the New Jersey Hospital Association.

Instead of reiterating what you have heard from the physicians, I would only like to add a few points if I may.

One is that we feel strongly about --

ASSEMBLYMAN OTLOWSKI: Excuse me.

MR. BECKER: Sure.

ASSEMBLYMAN OTLOWSKI: Some of the questions that I was asking the doctor just a moment ago -- are you in a position to answer any of those questions? What the total cost -- maybe I can get that from the Health Department.

MR. BECKER: Ms. Goldschmidt probably has that information.

ASSEMBLYMAN OTLOWSKI: Pursuing the questions that I was asking the doctor, can you be of any help to us on some of the questions that I was asking him?

MR. BECKER: Which ones specifically, Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: About what would be a better way to enlarge the umbrella so you would get better coverage. What would be a better way of assuring that the patients were getting better and more total care? What would be a better way of fitting psychiatry into this DRG system?

MR. BECKER: Fitting it into the DRG system, if it is to be fit into the DRG system, must be done by expanding DRGs 426 and 430, which is the psychosis and the depression. Those seem to be the two areas into which most patients who go into our hospitals fall. The length of stay that is allowed, from what we have been able to determine, is totally inadequate in terms of the total patient care.

ASSEMBLYMAN OTLOWSKI: Do you figure if you increase the 426 category --

MR. BECKER: To take in some of the other diagnosis. Psychosis, from what I understand, is a very broad catch-all, and certainly there should be other categories that could go into that, and extending that length of stay, that period of time.

ASSEMBLYMAN OTLOWSKI: Okay.

MR. BECKER: The problem with the DRG system is that it works fine when you are talking about a gall bladder, but when you start talking about diseases of the mind, it is very difficult to find an average person, or an average psychosis, or an average depression. They are all over the lot.

However, I understand the dilemma of the Department, which is that it is attempting to keep the DRG system consistent in keeping everything into an average length of stay. But I think in this case, there are certain needs to be looked at, in expanding those particular systems.

One of the other tyrannies of the system, at least as it relates to psychiatry, is that it really does not allow for any kind of innovative programs. Anorexia is a good example. There are no

hospital-based institutions that have anorexia programs because it is about an 80-day length of stay. The only one which is doing it in our State, as far as I know, is the Carrier Clinic, and New York City hospitals send patients to that particular facility because it is such a good program. Our hospitals feel they could offer that type of program just as well, but under the DRG system, there is just no way that they can.

ASSEMBLYMAN OTLOWSKI: The hospitals could offer that system if they were adequately compensated?

MR. BECKER: Yes. But it does take care of any of the innovative programs that we might try to do in the psychiatry end of things.

Again, I think it has to be taken as a separate issue, and we would certainly wholeheartedly recommend going towards a Task Force or "re-upping" that committee --

ASSEMBLYMAN OTLOWSKI: How about if the Task Force looked at what you are speaking of, and looked also at that 426 to see what could be done with that to make it more realistic, or at least to meet some of the requests that have been made here? Would that make sense?

MR. BECKER: Yes. We would like to put a time frame on it, where we would report back to you and your committee --

ASSEMBLYMAN OTLOWSKI: What kind of time frame?

MR. BECKER: I would have to leave that up to the experts, to our psychiatrists. I would think six months to one year would be adequate time.

ASSEMBLYMAN OTLOWSKI: All right. Do you want to go on?

MR. BECKER: That is pretty much it, Mr. Chairman. I don't want to take up too much time.

ASSEMBLYMAN OTLOWSKI: Evidently you feel pretty strongly that if a Task Force were formed, you would go into that 426 and into some of these other problems that were mentioned and we might come up with something.

MR. BECKER: I think it would certainly be worthwhile to explore it from both sides, and possibly Ms. Goldschmidt could give her side of it, why she is opposed to it; and also, why the Psychiatry

Association would like to see it expanded. There could be a possible meeting of the minds there.

ASSEMBLYMAN OTLOWSKI: Presently, we have a waiver that is probably good for what? A year or two?

MR. BECKER: It is good for two more years, starting October.

ASSEMBLYMAN OTLOWSKI: Two years. Is there any inkling of what the Federal government is thinking of in this area, at this moment?

MR. BECKER: They are struggling themselves in an attempt to come up with psychiatric DRGs. They do not have them at the present time; they more or less leave them out of the system. There is certainly a movement afoot to try to put them under a DRG system.

ASSEMBLYMAN OTLOWSKI: If we come up with something as a result of this task force, as a result of enlarging the umbrella, would it be helpful to the overall view of even the Federal government, eventually?

MR. BECKER: I would think they would certainly look at our program; absolutely. They have looked at it now and I believe they feel it is inadequate because they have not adopted it, when they adopted the original DRG program which was taken off of our system.

ASSEMBLYMAN OTLOWSKI: Is there anything else you want to add?

MR. BECKER: No, that is it.

ASSEMBLYMAN OTLOWSKI: No one has said, up to this point, anything about taking psychiatry completely out of the DRG system and looking and finding something else. You are not ready to --

MR. BECKER: Well, I think that is what Dr. Nadel recommended. We certainly believe that would be the optimal way of doing it, because at this point --

ASSEMBLYMAN OTLOWSKI: Has he got a ready substitute that he is going to put on the table?

MR. BECKER: I am sure that could be taken care of in fairly quick time.

ASSEMBLYMAN OTLOWSKI: What I would like to suggest is, let's put it on paper, let's take a look at it. All right?

MR. BECKER: I would be willing to work with that.

ASSEMBLYMAN OTLOWSKI: Could we hear -- Faith, just hold the horses, all right? (Laughter) Could I hear from Dennis Bruschi?

Dennis, would you want to give us your name and who you are representing?

DENNIS BRUSCHI: Yes, thank you. I am Dennis Bruschi, and I am the Deputy Director at Newark-Beth Israel Medical Center.

I guess I speak at a grassroots level, rather that on a broad base as far as medical approach to the whole concept of whether the appropriateness of DRGs in the State of New Jersey is indeed hampering delivery of services. However, I would like to present you with my perspective.

ASSEMBLYMAN OTLOWSKI: Before you start, let me ask you a question. At Beth Israel, you have a very sophisticated cardiac unit, a surgical cardiac unit, don't you?

MR. BRUSCHI: That is correct, sir.

ASSEMBLYMAN OTLOWSKI: Is there usually a psychiatric treatment associated with that?

MR. BRUSCHI: Primarily, it is on a consulting basis. Patients are admitted for open heart surgery, and usually, if needed, we request the Department of Psychiatry for consultation. The new program --

ASSEMBLYMAN OTLOWSKI: In that surgical practice, is psychiatry used extensively?

MR. BRUSCHI: Yes.

ASSEMBLYMAN OTLOWSKI: It is.

MR. BRUSCHI: But it usually results on an ambulatory follow-up basis, upon discharge from the medical center.

I'll put a plug in for what we are doing. (Laughter)

ASSEMBLYMAN OTLOWSKI: I just wanted the record to show that.

MR. BRUSCHI: As an annex to that, we are on the threshold of starting heart transplants, and as a heart transplant center, we do see a very significant component of involvement in psychiatry, both preparation for staff as well as the loved ones and the recipients.

Thank you. I tried to set this up not quite as an outline, but as an analysis presentation. Just reading from my background here:

My responsibilities include management of a 27-bed psychiatric unit; this 27-bed complement is broken down into 15 adult voluntary beds, eight adult involuntary and four adolescent involuntary. I think that you --

ASSEMBLYMAN OTLOWSKI: Involuntary?

MR. BRUSCHI: Involuntary.

The problems that are coming with the DRGs, as I see them, is that you are having many different kinds of programs taking place and you also have varying levels of acuity of care taking place, but you are taking a universal approach to the problem.

As I see the problem, it is difficult to adjust the psychiatric DRG inpatient reimbursement rates to reflect implementation of new services and modification in acuity of care. Let me give you an example of how the problem arises. Within the New Jersey Hospital reimbursement system, there exists, as we all indicated previously, nine mental disorder DRGs. The rates for these nine DRGs at Newark-Beth Israel Medical Center were calculated on a basis of operating a 15-bed voluntary adult unit. However, in October 1984, Newark-Beth Israel Medical Center initiated an expansion of this inpatient psychiatric service -- eight adult involuntary beds and four adolescent involuntary beds. This expansion entailed the initiation of a new service requiring a higher level of nursing care.

The problem: Rates of reimbursement have not been altered, and as of this date, we are being paid for involuntary psychiatric services on the basis of voluntary care. That is the problem that we are facing.

I just want to go through the analysis for you as far as what is the difference between a voluntary and an involuntary, so you can appreciate the problem. Herewith is a summary identifying differences and acuity of care in an involuntary unit. Patients are too ill to voluntarily sign into a hospital for treatment; these patients require more intensive care. The acuity level of the patient's illness is higher on the involuntary unit, designating it as an intensive psychiatric care unit. Also, there are two seclusion rooms -- this is just our situation -- on the involuntary unit for 12 patients, a ratio

of 1:6, to manage and protect the violent, uncontrollable patients and/or to use as holding rooms for emergency room relief.

There is a higher number of full-time employees, FTEs, on the involuntary unit; therefore, nursing staff comprises the largest percentage: 19.5 FTE nurses for a 15-bed involuntary unit and 14.5 FTE nurses for a 15-bed voluntary unit. I am sorry; that should have been 12. Let me repeat that: 19.5 FTE nurses for a 12-bed involuntary unit and 14.5 FTE nurses for a 15-bed voluntary unit.

The nurse-patient ratio, just a nursing ratio, is 1.63 for the involuntary unit and .97 for voluntary unit. Staff-patient ratio, that is, nursing plus support, is 1.78 for involuntary, and 1.21 for voluntary.

Let's go through the average length of stay. For the voluntary unit on the average, it is 8.7; for the involuntary, it is 12.3. Broken down for the involuntary, for the adult it is 11.8 and for the adolescent it is 13.2.

To proceed, patient care requirements in the involuntary unit are more intense and demand more individual staff attention to reduce potentially dangerous situations, and provide a more safe environment. Patient safety is at greater risk due to acuity, seclusion occurs more frequently, there is more one-to-one observation needed, restraints are applied more often, nurse monitoring is increased for suicidal and homicidal behavior, patients are more often rapidly tranquilized, elopement risk is greater, therapeutic interventions are constant, and we are experiencing higher utilization as our service becomes known.

Four beds -- this is for the adolescent -- are appropriate for adolescents and eight beds are for adults, necessitating separate nursing staff in each area on the involuntary unit. That is 24 hours per day. Documentation, record-keeping, and staff meetings required by both the State Department of Health and JCAH [Joint Commission on Accreditation of Hospitals] necessitate staff devoting adequate time for quality of care and their accountability.

I only wanted to provide you with the distinction between the acuity care levels. My recommendations are:

-I am a strong suppporter of the New Jersey Hospital DRG system, for even though you can moan and groan, I have not heard another alternative. This methodology of reimbursement is not the end-all; it only provides us with a means to manage a hospital component of a statewide health delivery system. The DRGs are merely measures of tools; they are a language -- a language of logic.

-The needs of the community service are evolving. It is essential that our system of hospital reimbursement be dynamic enough to adjust to these evolving needs. To solve the psychiatric inpatient reimbursement problem, you need merely a formal review procedure and you have to establish a timetable to come out with an action.

-Preliminary discussions with State reimbursement personnel indicate an appreciation of the situation. However, they have expressed concern in coming forth with a universal solution that will please all hospital providers. While this problem remains unaddressed, it is questionable that services provided can be maintained without immediate adjustment to our reimbursement.

ASSEMBLYMAN OTLOWSKI: Evidently you are enthusiastic about the DRG system, because, you point out, you have not seen anything else.

MR. BRUSCHI: I would not say enthusiastic; I would say I would accept it because I don't see anything else there.

ASSEMBLYMAN OTLOWSKI: Let me ask you this question. You heard the discussion we had today here of, number one, having a task force appointed and making a time frame, say, of six months when they can come back and too look at the 426, to see if it is possible to expand that, to see if it is possible to make that more workable and acceptable to psychatric care.

The other thing is determining, aside from 426, what else can be done to bring about better psychiatric care under the DRG. Would you have any comments about that? What would you think about that?

MR. BRUSCHI: I think that --

ASSEMBLYMAN OTLOWSKI: Maybe you will not be enthusiastic, but would that be acceptable to you? (Laughter)

MR. BRUSCHI: It sounds reasonable.

I think there has not been a force, a political force, a pressure point to start dealing with that specific service. The other services are more commonplace: cardiology, perinatology. Psychiatry is not relative to other types of services, and in the State is really not that politically power-base oriented to have a force to really address it. And I think an entity of that nature would be a reasonable approach. The only problem is the people who participate have to leave their hats when they walk in the door and think systems-wise, rather than the provider vested-interest approach.

ASSEMBLYMAN OTLOWSKI: Is there anything else you want to add to that, Dennis?

MR. BRUSCHI: I think that what I hear is a problem that is on a national basis as well, and I think that part of it is, as I learned from psychiatrists, that the hardest thing is to define your problem. What is happening in our environment is that in psychiatry, there is no cut-and-dry, "where does the service level end and then a new alternative begins?" In surgery, the person goes into the OR; they are treated and then they are discharged. In psychiatry, it is hard to see the results; and then what happens is, we are combining acute, interim, and chronic care.

Simultaneously, the State of New Jersey has adopted a de-institutionalized approach to push the people -- not so much push, but try to better utilize long-term facilities by having the acute care facilities participate in a screening process. As a result, we now are facing these problems. We have formal involuntary units that we never had about three years ago: adolescent and adult. That is a result of the change in the environment within the State of New Jersey. However, the DRGs are capable of reflecting that adjustment. My recommendation is that we do not use a simplistic approach. We do not take it and average it out to come up with an adjustment to identify the cost, but rather we identify additional DRGs so then we can compare the different providers according to the DRGs.

Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much.

Faith, can we go now? You want to come up? I am sorry to have done this to you, but I think it was better to do it this way, to bring it into better focus.

FAITH GOLDSCHMIDT: I enjoyed listening to the other testimony.

ASSEMBLYMAN OTLOWSKI: Faith, just for the record, give us your name and the Department that you are representing, and tell us also for the record the people that are sitting with you here.

MS. GOLDSCHMIDT: I am Faith Goldschmidt, Director-Designate of the Reimbursement Systems, Development Evaluation and Research. With me are Katherine Grant-Davis, Assistant Director-Designate, Hospital Reimbursement and Robert Fogg, Health Systems Specialist I, Health Systems Services.

Our three programs are part of the Division of Health Planning and Resources Develoment of the New Jersey State Department of Health.

I would like to thank you for calling this hearing on the issues surrounding psychiatric care and psychiatric DRGs in New Jersey's acute care general hospitals. I think there is a great deal of misinformation, and a lack of communication between the health care industry and the Department of Health on this issue.

I have already provided a lengthy written statement which contains a number of attachments that is sitting on the table. The issue of psychiatric DRGs and psychiatric care in New Jersey is an important one, and enough pertinent material should be presented to provide an understanding of several issues, which I will summarize in this oral testimony.

ASSEMBLYMAN OTLOWSKI: Do you all have a copy of this? Do we have copies for the committee?

All right. Go ahead, I'm sorry.

MS. GOLDSCHMIDT: The material presented in this testimony and in the written statement will show that:

-Number one, the Department of Health is aware of the concerns of the health care industry, physicians, and psychiatrists;

-Number two, the Department has worked, and continues to work, with groups within and outside of New Jersey to address DRG issues and psychiatric issues;

-Number three, the DRG system in New Jersey has not eroded the quality of care, as is sometimes alleged;

-Psychiatric beds, units, and cases have increased since 1980 in New Jersey's acute care general hospitals;

-And number five, the vast majority of acute care hospitals have not indicated that psychiatric DRGs are a financial problem.

If, after the Committee has managed to go through this large statement, any of you have questions, please do not hesitate to contact either myself, Ms. Grant-Davis or Mr. Fogg at the Department of Health.

I have divided this testimony into seven sections. Section one is background. In 1980, the New Jersey State Department of Health implemented a system of payment to acute care hospitals based upon Diagnosis Related Groups, DRGs. All hospital patients can be assigned to a DRG, and patients in a given DRG are expected to consume similar amounts of resources. An average hospital payment rate, a DRG rate, can be calculated for each DRG and this rate includes all acute care services for that patient in any given DRG.

Section two, DRG Construction and Coding: In 1979, the Health Care Financing Administration, HCFA, of the Federal government set up a National Steering Committee to construct a new set of DRGs. The old 383 DRGs were a first interaction at payment by DRG and were used in New Jersey in 1980 and 1981.

All diagnoses and procedures have a numeric code, an ICD-9-CM code, that is specific to each diagnosis and procedure. The diagnosis and procedure code were used to form the DRGs. As each set of DRGs was constructed by the National Steering Committee, it was brought back and reviewed in New Jersey by an expanded Commissioner's Physicians Advisory Committee called CPAC. Each set of DRGs was reviewed by New Jersey physicians with specialties in that set. MDC 19, mental diseases and disorders, was reviewed by a group consisting of six psychiatrists, one psychiatric nurse and other health care representatives. The names are listed in Attachment B of the written statement.

The recommendation of the New Jersey group and New Jersey cost data were used to refine the draft DRGs into a set of 468 DRGs that have been used by New Jersey since 1982. The Department has

continuously worked with the Federal government on DRG construction issues. Primarily, because of New Jersey's real-life experience with the 468 DRGs in 1982, revisions were made to those DRGs in July 1983. The revised DRGs were implemented by Medicare nationwide in October 1983.

New Jersey physicians have also had input by developing trim points -- that is, the shortest and longest day in a range of days typical for patients in each DRG for use in New Jersey. And I would like to mention here that we had, from 1982 to 1984, eight outlier categories in which patients were billed charges. As of May of this year, we have six outlier categories and they include high length of stay, low length of stay, clinical, low volume, same-day stay, and transfers.

Section three, Payment for psychiatric DRGs: A DRG rate for a psychiatric patient is constructed as is a DRG rate for other acute care inpatients. Direct patient care costs and indirect costs are blended and adjusted to account for labor market area and teaching status.

Rates in New Jersey are hospital specific. They include coverage for uncompensated care, apply to all patients and third-party payers in each acute care general hospital, and again, cover all acute services for each patient.

Section four, Experience of the Department with psychiatric issues: Three areas of concern about the use of psychiatric DRGs have been brought to the Department of Health's attention. Number one is clinical issues, number two is financial issues, and number three is quality of care.

The clinical issue consists of two parts -- the use of the ICD-9-CM codes for psychiatric patients and the grouping of those codes into particular configurations. Holy Name Hospital, particularly Dr. Charles Carluccio; Underwood Hospital, and a few other individuals have brought these issues to the Department's attention. Coding and DRG construction are not under the authority of the Department of Health. They are under the authority of the Federal government, so referrals have been made to the groups with authority. As of March 1985, the

Prospective Payment Assessment Commission [ProPAC] has had authority over these two issues.

ProPAC indicated in a May 1985 letter that other than a letter from me last month, no other correspondence has been received on psychiatric DRGs. HCFA has commissioned a study on the psychiatric DRGs and no changes will be made to those DRGs until that study is completed. Attachment E of the written statement contains correspondence —

ASSEMBLYMAN OTLOWSKI: Excuse me -- would you repeat that? No studies...what?

MS. GOLDSCHMIDT: HCFA commissioned a study on the psychiatric DRGs and no changes will be made to those DRGs until that study is completed.

ASSEMBLYMAN OTLOWSKI: The Federal government has said this?

MS. GOLDSCHMIDT: Yes.

ASSEMBLYMAN OTLOWSKI: All right, good. I just wanted that to be emphasized.

MS. GOLDSCHMIDT: The second issue is financial.

As part of New Jesey's DRG system, Utilization Review Organizations [UROs] review continued stay on acute care patients, including psychiatric patients. If there is a medical reason why the patient must stay in the acute care setting and there is adequate documentation in the medical record, the patient stays. If the stay is above the high trim point, the hospital bills charge up until May of this year, or the high length of stay per diem plus the DRG payment rate. Hospitals do not lose money on valid high length of stay outliers.

Likewise, indigent patients are not refused care or pushed out because of the DRG system in New Jersey. Our system covers uncompensated care. Hospitals recoup the money spent to treat those patients.

Interestingly enough, only two hospitals -- St. Clare's and Elizabeth General -- have appealed their DRG rates because of their unique case mix, which included treatment of children and treatment of involuntarily admitted patients. These hospitals are supplying hard data to the Department to support their claims.

The third issue mentioned is quality of care. Besides the continued stay review, the Utilization Review Organizations also monitor other areas of quality of care. In addition, there have been no patient appeals on the psychiatric DRGs brought to the Department.

A broad study conducted by a large Utilization Review Organization in 1983-84 showed that based upon their data, no erosion of the quality of care had been caused by the DRG system. Any problems found were due to existing hospital practices such as poor discharge planning, lack of patient education, or improper treatment. If anything, the DRG system has focused attention on quality of care issues, and the public and health care industries are more willing to question health care practices.

Section five, Data: There are two attachments in the written statement, attachments F and G, which contain data. Basically, the data show that across the State, the number of psychiatric cases, beds and units have increased since 1979 or 1980. Length of stay has decreased, by almost two days since 1980. Based upon the data, a few of the DRGs warrant further investigation, and my choices are DRGs 430 and 431. That is explained in the written statement.

Hospitals have not provided any hard data to substantiate allegations that payment for psychiatric DRGs is inadequate, inappropriate discharges are occurring, or care is eroding because of the DRG system.

Section six, Present efforts of the Department of Health: First, the Department of Health and the Department of Human Services are cooperating in several areas. One is that both Departments are in agreement that chronic and acute care psychiatric services can integrate to stabilize a patient with an acute episode, and then return that patient to the least restrictive setting as soon as possible, as should occur in a unified service system. Acute care services should be used for the acute patient, not for a patient who needs a lesser level of care.

A second cooperative effort between the two Departments is a joint State Plan. A third is the development of the joint draft licensing standards, and a fourth cooperative effort is an

interdepartmental agreement being finalized now to provide psychiatric services for involuntarily committed patients in general hospitals.

The Department of Health and the Department of Human Services anticipate continued cooperative efforts to provide a unified system of psychiatric service throughout the State of New Jersey.

The second effort of the Department is its continuing efforts to work with the New Jersey health care industry to solve problems under Departmental authority. However, any allegations must be backed up by hard data. The Department can not affect change based on unsubstantiated claims. The Department itself continues to monitor data and quality of care to ascertain any changes or problems.

Third, the Department continues to work with groups outside of New Jersey such as ProPAC, to affect necessary change in all areas of the system. New Jersey's experience with DRGs can be extremely valuable. The Department will keep abreast of the HCFA study on psychiatric DRGs. It may simply be that there were not enough records on the data base from which the 468 DRGs were constructed to show significant differences in patients at a level below the present DRGs, and perhaps now is the time to redefine those DRGs.

Lastly, Summary and Recommendations: In summary, the Department has a history of cooperation with the health care industry in New Jersey and outside of New Jersey on DRG system issues, and is committed to the continuation of such cooperative efforts.

The Department has two recommendations. First, the Department recommends waiting until HCFA's study on psychiatric DRGs is complete. If changes to DRG coding or construction are made from nationwide experience, the Department will adopt those changes for use in New Jersey. We also recommend -- and this is very important -- close interaction with ProPAC during this time period for information flow to and from the Federal government. The task force that has been mentioned here several times would be an ideal way to do that.

Second, the Department recommends no change in payment for psychiatric DRGs be made at this time. There is no evidence of erosion of quality care and no evidence of a statewide problem with payment. A new outlier methodology was implemented on May first of this year, and

the ramifications have yet to be determined. Individual hospitals may have specific payment problems -- such as St. Clare's and Elizabeth General -- and if so, should work with their rate analyst to find the best course of action.

As always, the Department welcomes and encourages comments and statistical efforts that point to constructive change. We look forward to continued cooperative efforts. I would very much like to discuss with the New Jersey Psychiatric Association their testimony that they have made here. We would also be very happy to provide this Committee with any further material, or to discuss this issue further.

Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

Let me ask you this. I just want to say I think you made a very comprehensive and at the same time a very pointed presentation. I really appreciate the work that you put into it.

MS. GOLDSCHMIDT: Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much. You made it easier for us.

What I would like to suggest, at this point -- I want the staff people to look over all this testimony, and afterwards, I want them to talk to me so that I can make some recommendations to the Committee.

But from what you say, you are indicating -- at least, I believe you are indicating -- that you feel this task force that was suggested would be good to look at some of the things that we were talking about. I think, too, that we ought to put a time frame on that so the task force can get going and complete the work in a certain period. But I would not want to lay that period down at this point until after I had the chance to look at this testimony.

I think, that from what you said, you are not only willing but practically ready to sit down with that Task Force at almost any time now.

MS. GOLDSCHMIDT: Tomorrow.

ASSEMBLYMAN OTLOWSKI: Good. Let me just talk to the staff people, and then I am going to be in touch with you. Then maybe we can

suggest a time frame and who ought to be on that task force, when they should meet, and when it should be completed. Is that agreeable to you?

MS. GOLDSCHMIDT: Yes, it is. That would be very good.

ASSEMBLYMAN OTLOWSKI: And would you do me the personal favor of telling the Commissioner that I not only appreciate your appearance, I appreciate the way the presentation was made? In fact, I have been sitting here a long time and this is one of the times that I have been impressed by a presentation.

MS. GOLDSCHMIDT: Thank you.

ASSEMBLYMAN OTLOWSKI: Will you tell him that?

MS. GOLDSCHMIDT: Yes, I will.

ASSEMBLYMAN OTLOWSKI: This will give me a chance also to talk to some other people. The Legislature meets on the 17th; I want these dates and the task force to be set up so that I can get back to Faith and we can work this thing out. Okay?

And again, thank you very, very much. I appreciate everyone's patience and as a matter of fact, I think that the whole thing here today -- I am surprised today at how well everything ran. You know something? I am convinced it is because I was doing it by myself. (Laughter)

Thank you very, very much.

(Hearing Concluded)

APPENDIX

June 5, 1985 - Outline of Testimony on Psychiatric DRGs by:

Levon Z. Boyajian, M.D.

Chairman, Department of Psychiatry
St. Joseph's Hospital and Medical Center
Paterson, New Jersey

Diplomate American Board of Psychiatry and Neurology in Psychiatry 1963
Fellow - American Psychiatric Association 1971
Certified in Administrative Psychiatry, American Psychiatric Association 1971

Member American Psychiatric Association, Commission on Certification in Administrative Psychiatry 1974 - 1979
Member American Psychiatric Association Task Force on Prospective Payment - Clinical Advisory Group 1984 -
Member New Jersey Hospital Association - Mental Health Committee 1978 -

DRGs were initially developed at Yale as an inpatient classification system and not for reimbursement purposes.

It is based on the assumption that hospital resource consumption could be approximated by the patients' length of stay. The 383 DRGs worked out at Yale were expanded to 467 to hopefully correct some of the defects in the original DRGs. Initial objections have still pertained to psychiatry.

In New Jersey S446 established DRG based per case prospective payment system. Additional important features are:

1. The law extended the state's authority to all payers.

2. The cost of uncompensated care was spread among all payers.

3. The Hospital Rate Setting Commission was established to approve or adjust all hospital rates.

1980 - 26 hospitals in system

1982 - remaining hospitals included

1985 - 126 general hospitals are DRG based. 44 have psychiatric units

Critical issue was exculsion of private psychiatric hospitals from DRG based system.

Early on Psychiatric Society was not successful in influencing Health Department to critically review system as it applied to psychiatry.

At New Jersey Hospital Association Seminar in early 1980s, data was presented which showed psychiatric DRGs did not meet necessary criteria for system to be effective. Health Commissioner was irate and accused researchers of dishonesty.

On Federal scene American Psychiatric Association was able to have psychiatry excluded till further studies could be done. Even preliminary evidence clearly indicates current DRGs as constituted do not meet requirements of normal distribution curve; variations are not explicable by DRGs and the other factors taken into consideration.

Evidence all suggests it is not a workable system for psychiatry.

LZB:meh

2x

NICHOLAS F. VIDETTI, M. D.
127 UNION STREET
RIDGEWOOD, NEW JERSEY 07450

TELEPHONE 444-4103

BACKGROUND

General Hospital Committee of New Jersey Psychiatric Association - Chairman
Councilor - New Jersey Psychiatric Association
Chief of Psychiatry at Holy Name Hospital - Teaneck
Staff Psychiatrist at Valley Hospital - Ridgewood
Private Psychiatric Practice - Ridgewood

Diagnosis does not indicate length of stay in psychiatry.

DRG diagnoses for psychiatry number eight and lump most patients in 430, most of the rest in 426, so do not differentiate.

DRG diagnoses in psychiatry based on outmoded diagnostic scheme, rather than one that has been in use for the past five years in the United States. This recent system includes axes which might make DRG's more appropriate, if used.

State Health Department with DRG system is pressuring for decreased length of stay and decreased hospital cost while State Department Human Services is pressuring in the opposite way - for general hospitals to care for deinstitutionalized chronic patients, without families, social skills or networks. These therefore require increased length of stay for a given diagnosis.

DRG implementation has caused psychiatry departments in general hospitals to go from a surplus to deficit revenue position. Outpatient and in-patient staff positions have been decreased.

HNH

HOLY NAME HOSPITAL

INTER-OFFICE MEMORANDUM

TO: Dr. N. Videtti

FROM: Ms. J. Francisco

DATE: June 4, 1985

Please find listed below the DRG statistics you requested.

DRG		1984 & 1985
424	Mental Disorders, With any O.R. Procedure	12
425	Acute and Adjustment Reactions and/or Psychosocial Neuroses, Medical	29
426	Neuroses, With Principal Diagnosis of Depressive Neuroses, Medical	68
427	Neuroses, Without Principal Diagnosis of Depressive Neuroses, Medical	7
428	Disorders of Personality and/or Impulse Control, Medical	4
429	Organic Disturbances and/or Mental Retardation, Medical	35
430	Psychoses, Medical	427
431	Childhood Disorders, Medical	1
432	Other Diagnosis of Mental Disorder, Medical	1
433	Substance Use Disorder and/or Substance Induced organic Disorder, Left Against Medical Advice, Medical	13
434	Principal Diagnosis of Drug Dependence, Medical	4
435	Principal Diagnosis of Drug Abuse, Medical	0
436	Principal Diagnosis of Alcohol Dependence, Medical	0
437	Principal Diagnosis of Alcohol Abuse, Medical	6
438	Alcohol and/or Substance Induced Organic Mental Syndrome, Medical	37

If you need any further information, please let me know.

Kenneth J. Rubin, M.D.
Diplomate, American Board of
Psychiatry and Neurology, Inc.

Kenneth J. Rubin, M.D., P.A.
170 Morris Avenue
Long Branch, New Jersey 07740

(201) 870-3535

OUTLINE OF TESTIMONY OF
DOCTOR KENNETH J. RUBIN ON JUNE 5, 1985

Vice President, Internal Affairs, New Jersey Psychiatric Association

Member, General Hospital and Psychiatry Committee, New Jersey Psychiatric Association

Private Practice: Long Branch

Attending: Monmouth Medical Center, Long Branch.

Chairman, Quality Assurance Committee, Department of Psychiatry, Monmouth Medical Center

1. Clinical treatment of mentally ill is compromised by the restraint of a shorter length of stay.

2. DRG is discriminatory against the mentally ill because co-morbid conditions are not included.

3. Malpractice is mandated for practitioners, but inadequate length of stay raises the risk of possible malpractice suits.

4. DRG's do not take into account intensity of treatment or allocation of resources needed to treat the mentally ill.

5. Clinical outliers were done away with to save money, not because they were clinically inappropriate trim points.

6. Psychiatric diagnoses do not have a normal curve, therefore, DRG's are inappropriate.

7. Not all psychiatric hospitals are included as are medical and surgical hospitals.

5X

Testimony of the New Jersey Psychiatric Association General Hospital Committee, June 5, 1985, William R. Nadel, M.D.

Solutions for the deleterious effects of the New Jersey DRG reimbursement system on the mentally ill and services to them:

1. Exclude services rendered to psychiatric patients in general hospital psychiatric units until the methodology can be developed which adequately deals with these diagnoses.
   a) the present system discriminates against patients with a primary diagnosis of a mental illness and is not only inequitable but probably unconstitutional.
   b) the Federal government in it's Medicare DRG reimbursement system has excluded psychiatric units in general hospitals until a methodology can be developed to handle the psychiatric diagnoses and treatment within the DRG reimbursement system, acknowledging that this is not the case at present.
   c) patients with psychiatric diagnoses at some hospitals are reimbursed under the DRG system and in other hospitals under the Share system so that in psychiatry the system is inequitable to patients and hospitals depending on where they happen to be located.
2. Extend a modified DRG reimbursement system to all psychiatric units or hospitals treating mentally ill patients excluding Federal, State or County sponsored units or hospitals unless they elect to be included in this reimbursement system.
   a) this system would treat patients and hospitals in all parts of the state equitably without regard to accidents of location or socio-economic status.
   b) modifications should include:
      1. reimbursement acknowledgement of co-morbid conditions, both medical and psychiatric.
      2. reimbursement should make allowance for stay on medical/surgical units which may be necessitated by the psychiatric illness i.e. time in an intensive care unit

or cardiac telemetry unit following suicide attempts which may result in lacerations, fractures or overdoses with serious medical/surgical sequelae.

3. chronicity of illness must also be taken into account as typically those with chronic illness require more time than others with the same diagnosis when the illness is not chronic.
4. number of prior hospitalizations and/or duration of hospitalizations must be taken into account. Some people do not benefit from repeated brief hospitalizations and require a longer length of stay, having demonstrated the inadequacy of brief hospitalization for them.
5. severity of functional disability
6. severity of psychosocial stressors and sufficiency of family and other support systems.

NJHA NEW JERSEY HOSPITAL ASSOCIATION

at the Center for Health Affairs (609) 452-928

746-760 Alexander Road
CN-1
Princeton, New Jersey 08540-0706

Louis P. Scibetta FACHA
President

TESTIMONY OF CRAIG A. BECKER

ASSISTANT VICE PRESIDENT FOR GOVERNMENT RELATIONS

ON

PSYCHIATRIC DRGs

BEFORE THE

ASSEMBLY CORRECTIONS, HEALTH & HUMAN SERVICES COMMITTEE

June 5, 1985

8x

Mr. Chairman, I am Craig Becker, Vice President for Government Relations at the New Jersey Hospital Association (NJHA) which represents 106 acute care hospitals, several of which have Mental Health units connected with their facilities. We applaud the Committee for shedding light on the problem our hospitals face in regard to payment for Psychiatric DRGs.

The Psychiatric DRGs payment problem, much like the DRG system, is a complex one. The DRG system attempts to average all payments, making sure that our efficiently run institutions are kept whole. Some areas may receive more funds than others, but in the end result, hospitals receive the necessary funds to operate.

However, there appear to be several serious flaws in the Psychiatric DRG payment system. First is that the DRG rates as currently cut include hospitals without psychiatric units. A patient who is admitted to an acute care hospital and determined to need psychiatric help and is discharged two days later, receives the same level of payment as a hospital which admits and keeps a patient through his or her course of treatment. It is obvious that the Acute Care hospital with the two day length of stay has received payment far in excess of care rendered, while the psychiatric hospital receives the "average" length of stay.

The second problem pertains to the way the DRGs are established. According to Andrew Kraemer, Chairman of NJHA's Mental Health Committee, and Program Director of Jersey Shore Memorial Hospital's Psychiatric Unit, 85 percent of the patient population falls into two DRGs--426 which is depression, and 430, psychosis. With DRG 430, there are many other diagnosis issues connected with psychosis which is not recognized by the DRG system. These issues have a tendency to make for a longer length of stay which results in a significant monetary loss for our hospitals. We believe DRG 430 should be expanded to take in other diagnoses or that reimbursement for this DRG be increased.

The payment system is just not fine enough to recognize the problems inherent in psychiatry. While averaging costs for various surgical procedures may be appropriate, it is not for diseases of the mind, which vary from each individual case.

Finally, another failing of the Psychiatric DRG is that they have taken away the ability of our hospital based programs to create new and innovative services in psychiatry. As an example, treatment for anorexia must be done outside of the hospital setting. The average length of treatment for this crippling disease is 81 days. Currently, only the Carrier Clinic, one of our premier specialty institutions is able to provide this service. In addition, mental health care for our elderly is a problem, as frequently it is difficult to differentiate between psychiatric problems and those of chronic conditions that need medical attention. The DRG system is not flexible enough to allow the additional diagnostic time necessary for these cases.

Mr. Chairman, the NJHA would very much support a task force made up of representatives from providers, consumers, and regulators to study this problem and report its findings back to the Legislature. We are most appreciative of the opportunity to discuss this vital matter.

INTRODUCTION

I am Dennis Bruschi, Deputy Director, Newark Beth Israel Medical Center (NBIMC). My responsibilities include management of a 27 bed psychiatric unit. The bed complement includes a 15 adult voluntary, 8 adult involuntary and 4 adolescent involuntary beds.

PROBLEM

It is difficult to adjust the psychiatric DRG inpatient reimbursement rates to reflect implementation of new service(s) and modifications in acuity of care.

SITUATION

Within the New Jersey hospital reimbursement system, there exists nine (9) mental disorder DRGs. The rates for these nine DRGs at Newark Beth Israel Medical Center were calculated on the basis of operating a 15 bed voluntary adult unit. However, in October of 1984, Newark Beth Israel Medical Center initiated an expansion of its inpatient psychiatric services--8 adult involuntary beds and 4 adolescent involuntary beds. This expansion entailed the initiation of a new service requiring a higher level of nursing care. The rates of reimbursement have not been altered and as of this date, we are being paid for involuntary psychiatric services on the basis of voluntary care.

JUSTIFICATION OF ADDITIONAL COSTS

Herewith is a summary identifying differences in acuity of care in an involuntary unit:

1. Patients are too ill to sign into the hospital for treatment voluntarily. These patients require more intensive care.

2. The acuity level of the patient's illness is higher on the Involuntary Unit designating it as an "intensive psychiatric care unit".

3. There are two (2) seclusion rooms on the Involuntary Unit for ~~15~~ 12 patients (ratio of 1:6) to manage and protect the violent, uncontrollable patients and/or to use as holding rooms for Emergency Room relief.

4. There is a higher number of full time employees (FTE) on the Involuntary Unit, therefore, nursing staff comprises the largest percentage.

19.5 FTE nurses for 15 bed involuntary unit

14.5 FTE nurses for 15 bed voluntary unit

NURSE-PATIENT RATIO:

1.63 Involuntary Unit

.97 Voluntary Unit

STAFF-PATIENT RATIO:

1.78 Involuntary Unit

1.21 Voluntary Unit

5. **THE AVERAGE LENGTH OF STAY (LOS) ON OUR PSYCHIATRIC UNITS DURING THE PERIOD JANUARY 1, 1985 TO APRIL 30, 1985 WAS AS** FOLLOWS:

VOLUNTARY UNIT 8.7 Days

INVOLUNTARY (SCREENING) UNIT 12.3 Days

INVOLUNTARY ADULT 11.8 Days

INVOLUNTARY ADOLESCENT 13.2 Days

6. Patient care requirements on the Involuntary Unit are more intense and demand more individual staff attention to reduce potentially dangerous situations and provide a more safe environment.

a. Patient safety is at a greater risk due to acuity.

b. Seclusion occurs more frequently.

c. There is more one-to-one observation needed.

d. Restraints are applied more often.

e. Nurse monitoring is increased for suicidal and homicidal behavior.

f. Patients are rapidly tranquilized more often (medicating patients every 15 minutes, ½ hour or one hour).

g. Elopement risk is greater (necessitating police action should the patient elope).

h. Therapeutic interventions are constant.

i. We are experiencing higher utilization as our service becomes known.

12X

j. Four beds are appropriated for adolescents and eight beds are for adults necessitating separate nursing staff in each area on the Involuntary Unit 24 hours/day.

k. Documentation, record keeping and staff meetings required by both the State Department of Health and JCAH necessitate staff to devote adequate time for quality of care and their accountability.

RECOMMENDATIONS

I am a strong supporter of the New Jersey Hospital DRG system. This methodology of reimbursement provides us with the means to manage the hospital component of a state-wide health delivery system. The needs of the community served are evolving. It is essential that our system of hospital reimbursement be dynamic enough to adjust to these evolving needs. To solve the psychiatric inpatient reimbursement problem, a formal review procedure needs to be established in a reasonable and timely fashion.

Preliminary discussions with state reimbursement personnel indicate an appreciation of the situation. However, they have expressed concern in coming forth with a universal solution that will please all hospital providers. While this problem remains unaddressed, it is questionable that the services provided can be maintained without immediate adjustment to our reimbursement.

Dennis J. Bruschi, Deputy Director
June 5, 1985

jmw

Oral Testimony Presented

to the

New Jersey State Assembly's
Corrections, Health and Welfare Committee

Assemblyman George Otlowski, Chairman

June 5, 1985

Hearing on Psychiatric DRGs

By: Faith K. Goldschmidt
Director Designate,
Reimbursement Systems Development,
Evaluation and Research
New Jersey State Department of Health

14x

Good afternoon Assemblyman Otlowski and Committee members. I am Faith Goldschmidt, Director Designate, Reimbursement Systems Development, Evaluation and Research. With me are Katherine Grant-Davis, Assistant Director Designate, Hospital Reimbursement and Robert Fogg, Health Systems Specialist I, Health Systems Services. Our three programs are part of the Division of Health Planning and Resources Development of the New Jersey State Department of Health.

I would like to thank you for calling this hearing on the issues surrounding psychiatric care and psychiatric DRGs in New Jersey's acute care general hospitals.

I have provided a lengthy written statement which contains a number of attachments. The issue of psychiatric DRGs and psychiatric care in New Jersey is an important one, and enough pertinent material should be presented to provide an understanding of several issues, which I will summarize in this oral testimony. I have also read the testimony of Dr. Willian Nadel from a December 1984 hearing. The material presented in this testimony and in the written statement will show that:

1. The Department of Health is aware of the concerns of the health care industry, physicians and psychiatrists.

2. The Department has worked, and continues to work, with groups within and outside of New Jersey to address DRG issues and psychiatric issues.

3. The DRG system in New Jersey has not eroded quality of care.

4. Psychiatric beds, units and cases have increased since 1980 in New Jersey's acute care general hospitals.

5. The vast majority of acute care hospitals have not indicated that psychiatric DRGs are a financial problem.

If after the Committee has read the statement, any of you have questions, please do not hesitate to contact me, Ms. Grant-Davis or Mr. Fogg at the Department of Health.

This testimony is divided into seven sections:

I. Background of New Jersey's DRG system

II. DRG construction and coding, emphasis on psychiatric DRGs

III. Payment for psychiatric DRGs

IV. Experience of the Department of Health with psychiatric issues

V. Data

VI. Present efforts of the Department on psychiatric issues

VII. Summary and recommendations

I. Background

In 1980, the New Jersey State Department of Health implemented a system of payment to hospitals based upon Diagnosis Related Groups (DRGs). All hospital patients can be assigned to a DRG and patients in a given DRG are expected to consume similar amounts of resources. An average hospital payment rate, a DRG rate, can be calculated for each DRG and this rate includes all acute care services for each patient in any given DRG.

II. DRG Construction, Coding

In 1979, the Healthcare Financing Administration (HCFA) set up a National Steering Committee to construct a new set of DRGs. The old 383 DRGs were a first interaction at payment by DRG and were used in New Jersey in 1980 and 1981.

All diagnoses and procedures have a numeric code, an ICD-9-CM code, that is specific to each diagnosis or procedure. ICD-9-CM, International Classification of Diseases, Ninth Edition, Clinical Modification, is an international code scheme that covers all health care settings.

Every ICD-9-CM diagnosis code was grouped into 23 broad groupings, called Major Diagnostic Categories or MDCs, based on organ system. Then the

MDCs were divided into DRGs, based upon variables that made a difference in length of stay of the 1.4 million national patient records in the data base used to construct these DRGs. Variables included diagnoses, procedures, age, sex, and discharge status.

As each MDC was constructed, it was reviewed in New Jersey by an expanded Commissioner's Physician Advisory Committee (CPAC).

Each MDC was reviewed by New Jersey physicians with specialties in that MDC. MDC 19, Mental Diseases and Disorders, was reviewed by a group consisting of 6 psychiatrists, one psychiatric nurse and other health care representatives (listed in written statement). The recommendations of New Jersey groups and New Jersey cost data (330,000 records) were used to refine the "draft DRGs" into a set of 468 DRGs that have been used by New Jersey since 1982. New Jersey experience with use of DRGs for hospital payment played an extremely important role in construction of the 468 DRGs. The Department has continued to work with the federal government on DRG construction issues. Primarily, because of New Jersey's "real life" experience with the 468 DRGs in 1982, revisions were made to those DRGs in July 1983. The revised DRGs were implemented by Medicare in October 1983.

New Jersey physicians also developed "trim points" - the shortest and longest day in a range of days typical for patients in each DRG for use in New Jersey.

III. Payment for psychiatric DRGs

A DRG rate for a psychiatric patient is constructed as is a DRG rate for other acute care inpatients. Direct patient care costs and indirect costs are blended and adjusted to account for labor market area, and teaching status.

Rates in New Jersey are hospital specific, include coverage for uncompensated care, apply to all patients and third-party payers in each acute care general hospital and cover all acute services for each patient.

IV. Experience of the Department with Psychiatric Issues

Three areas of concern about the use of psychiatric DRGs have been brought to the Department of Health's attention - clinical issues, financial issues and quality of care.

A. The clinical issue consists of two parts - use of ICD-9-CM codes for psychiatric patients and grouping of those codes into particular configurations. Holy Name Hospital, Underwood Hospital and a few other individuals have brought these issues to the Department's attention. Coding and DRG construction are not under the authority of the Department of Health, so referrals have been made to the group with authority. As of March 1985, the Prospective Payment Assessment Commission (ProPAC) has had authority over these two issues.

ProPAC indicated in a May 1985 letter, that other than a letter from me, no correspondence has been received on psychiatric DRGs. HCFA has commissioned a study on the psychiatric DRGs and no changes will be made until that study is completed. Attachment E of the written statement contains correspondence on the clinical issues.

B. The second issue is financial.

As part of New Jersey's DRG system, Utilization Review Organizations (UROs) review continued stay on acute care patients, including psychiatric patients. If there is a medical reason why the patient must stay in an acute care setting and there is adequate documentation

in the medical record, the patient stays. There is no reason for patients to be pushed out before they are medically ready to leave. If the stay is above the high trim, the hospital bills charges or the high length of stay per diem (May 1, 1985). Hospitals do not lose money on valid high length of stay outliers.

Indigent patients likewise are not refused care or pushed out because of the DRG system in New Jersey. It covers uncompensated care. Hospitals recoup the money spent to treat those patients.

Only two hospitals, St. Clare's and Elizabeth, have appealed their psychiatric DRG rates because of their unique case-mix. These hospitals are supplying "hard data" to the Department.

C. The third issue mentioned is quality of care. The UROs also monitor other areas of quality of care. No patient appeals on the psychiatric DRGs have been brought to the Department.

A study conducted by a large URO in 1983-1984 showed that, based upon their data, no erosion of care had been caused by the DRG system. Any problems found were due to existing hospital practices such as poor discharge planning, lack of patient education or improper treatment.

If anything, the DRG system has focused attention on quality of care and the public and the health care industry are more willing to question health care practices.

V. Data

There are two attachments to the written statement, F and G, which contain data. Basically, the data show that across the State, the number of psychiatric cases, beds and units have increased since 1979 or 1980.

Length of stay has decreased by almost 2 days since 1980. Based on the data, a few of the DRGs warrant further investigation (DRGs 430 and 431).

Hospitals have not provided any "hard data" to substantiate allegations that payment for psychiatric DRGs is inadequate or that inappropriate discharges are occurring or care is eroding because of the DRG system.

VI. Present Efforts

A. First, the Department of Health and the Department of Human Services are cooperating in several areas. One is that both Departments are in agreement that chronic and acute care psychiatric services can integrate to stabilize a patient with an acute episode, and then return that patient to the least restrictive setting as soon as possible, as should occur in a unified service system. Acute care services should be used for the acute patient, not for a patient who needs a lesser level of care.

A second cooperative effort is in the development of a joint State Plan. A third effort is in development of joint draft licensing standards for alcohol, drug and mental health services. A fourth cooperative effort is an interdepartmental agreement being finalized now to provide inpatient psychiatric services for involuntarily committed patients in general hospitals.

The Department of Health and Department of Human Services anticipate continued cooperative efforts to provide a unified system of psychiatric service throughout the State of New Jersey.

B. Second, the Department of Health continues to work with the New Jersey health care industry to solve problems under Departmental authority. However, allegations must be backed by "hard data". The Department

also continues to monitor data and quality of care to ascertain any changes.

C. Third, the Department continues to work with groups outside of New Jersey, such as ProPAC, to affect necessary change in all areas of the DRG system. New Jersey's experiences can be extremely valuable. The Department will keep abreast of the HCFA study on psychiatric DRGs. It may be that there were not enough records in the data base from which the 468 DRGs were constructed to show significant differences in patients at a level below the present DRGs, and now is the time to refine those DRGs.

VII. Summary and Recommendations

In summary, the Department has a history of cooperation with the health care industry in New Jersey and outside of New Jersey on DRG system issues, and is committed to the continuation of such cooperative efforts.

The Department has two recommendations. First, the Department recommends waiting until HCFA's study on psychiatric DRGs is complete. If changes to DRG coding or construction are made from nationwide experience, the Department will adopt those changes for use in New Jersey. We also recommend close interaction with ProPAC during this time period for information flow to and from the federal government.

Second, the Department recommends that no change in payment for psychiatric DRGs be made at this time. There is no evidence of erosion of quality of care and no evidence of a statewide problem with payment. A new outlier methodology was implemented on May 1, 1985 and the ramifications have yet to be determined. Individual hospitals may have specific payment problems and if so, should work with their rate analyst to find the best course of action.

As always, the Department welcomes and encourages comments and statistical efforts that point to constructive change. We look forward to continued cooperative efforts with the health care industry. We will be happy to provide this Committee with any other material or to discuss this issue further.

Thank you.

Testimony Presented

to the

New Jersey State Assembly's
Corrections, Health and Welfare Committee

Assemblyman George Otlowski, Chairman

June 5, 1985

Hearing on Psychiatric DRGs

By: The New Jersey State Dept. of Health
Health Planning and Resources
Development Division

23X

Statement Developed by Health Planning and Resources Development,
New Jersey State Department of Health

The issue of psychiatric care in the State of New Jersey is an extremely important and timely issue. In New Jersey, the acute level of services provided to psychiatric patients in acute care general hospitals is a part of New Jersey's payment by case system. Psychiatric patients at an acute level of care in those hospitals are billed an average rate per case, just as are all other acute care general hospital inpatients.

Serious concerns have been raised on the equity of the payment system as it applies to psychiatric patients. This statement presents material in response to those concerns.

By addressing a number of issues, the Department will show that it is aware of the concerns of the health care industry, physicians, and psychiatrists; that it has worked and continues to work with groups within New Jersey and outside of New Jersey to address psychiatric issues; that the payment by case system has not eroded quality of care; that psychiatric services, beds and cases have increased since 1980 in acute care general hospitals; and that the vast majority of the acute care general hospitals have not indicated that psychiatric DRGs are a problem.

This statement is divided into the following sections:

I. Background of New Jersey's Diagnosis Related Group (DRG) system; emphasis on psychiatric DRGs

II. DRG construction, coding and assignment; emphasis on psychiatric DRGs

III. Payment for psychiatric DRGs

IV. Experience of the Department with psychiatric issues

V. Data

VI. Present efforts of the Department on psychiatric issues

VII. Summary

I. Background

In 1980, New Jersey implemented a system of hospital payment based on Diagnosis Related Groups (DRGs). Under this DRG system, an acute care general hospital charges an average price for each case (DRG). Rates for each DRG are hospital-specific, apply to all payers, include uncompensated care and cover all acute care services for each patient within each DRG.

DRGs cover all patients, including psychiatric patients, in the acute care setting. In 1980 and 1981, a psychiatric patient was assigned to one of seven psychiatric DRGs of the old set of 383 DRGs. From 1982, to the present, a psychiatric patient is assigned to one of nine DRGs of the current set of 468 DRGs. These 468 DRGs are the same ones used nationwide by Medicare since October 1983.

Under the Health Care Financing Administration (HCFA), demonstration contract to New Jersey, all acute care services were included in New Jersey's DRG system.

II. DRG Constructing, Coding and Assignment

A. Construction

In the mid-1970's the Department of Health was working with the health care industry to develop New Jersey's DRG system. In 1976, the Commissioner of Health's Commissioner's Physicians Advisory Committee (CPAC) was formed, which was, and still is, instrumental in developing Department strategy. As specific needs arose on clinical issues, the CPAC was expanded, as for example, when the 468 DRGs were constructed.

In 1979, HCFA awarded a contract to Yale University to develop a set of DRGs based upon a new numeric medical record code scheme, International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). The old 383 DRGs were based on two prior code schemes. ICD-9-CM coding became international in 1979 and encompassed all possible diagnoses and procedures in any health care setting.

A data base of 1.4 million nationwide medical abstract records and 330 thousand New Jersey medical abstract records with costs included, were used to construct the 468 DRGs.

All diagnoses (the ICD-9-CM codes) were grouped into 23 broad categories, Major Diagnostic Categories or MDCs, based on organ system. Then each MDC was subdivided by attributes or variables, that made a significant difference in the length of stay (as a proxy for resource consumption). Some variables are principal diagnosis (the reason after study the patient was admitted to the hospital), secondary diagnoses, operating room procedures, age, discharge status, and sex of the patient. MDC 19, Mental Diseases and Disorders, contains 9 DRGs (see Attachment A).

A National Steering Committee which included Dr. Leo Lichtig, Department of Health and Dr. Warren Nestler, Medical Director of Overlook Hospital, met periodically over 2 years to construct the DRGs. In addition, as each MDC and its' DRGs were constructed, the material was brought back to New Jersey. An expanded CPAC committee of 65 New Jersey physicians reviewed each MDC. The physicians were selected for their expertise in each category. A summary of the meeting on the psychiatric MDC and list of New Jersey physicians, reviewers (6 practicing psychiatrists, 1 psychiatric nurse, and others) is included as Attachment B. In addition to the physician groups,

each MDC was reviewed by New Jersey's Hospital Care Subcommittee, a group composed of representatives from hospitals, third-party payers, utilization review organizations, medical record professionals, health systems agencies, the New Jersey Hospital Association and the Department of Health.

Recommendations from the New Jersey groups were taken to the National Steering Committee. The recommendations and the cost information from New Jersey's 330 thousand records were used to modify the 468 DRGs. New Jersey was the only state with "real world" experience in the use of DRGs for hospital payment and the considerable clinical as well as statistical input into the 468 DRGs was invaluable.

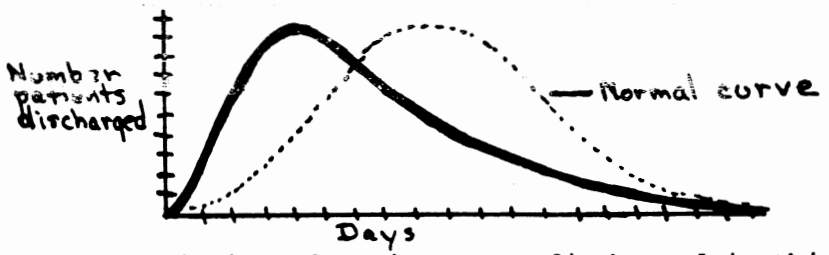
In addition to DRG construction, New Jersey physicians also provided clinical input into setting of New Jersey's "trim points". Each DRG has a range of days that is considered typical for an average, acute care inpatient. The lowest and highest days of the range are called "trim points". Trim points are DRG specific, and New Jersey's trim points differ from Medicare's trim points.

Trim points for New Jersey and Medicare's DRG systems for the current psychiatric DRGs are listed below:

		New Jersey	Medicare only
DRG 424*	Mental disorder, OR procedure	5-35 days	0-36 days
425	Acute, adjustment reaction; dysfunction	2-12 "	0-28 "
426	Neuroses, Dx1 depress. neur.	2-20 "	0-31 "
427	Neuroses, no Dx1 depress. neur.	2-17 "	0-29 "
428	Personality, impulse control disorder	2-24 "	0-30 "
429	Organic disturb., retardation	3-18 "	0-31 "
430	Psychoses	3-33 "	0-33 "
431	Childhood disorders	1-15 "	0-37 "
432*	Other mental disorders	2-26 "	0-20 "

*Clinical outlier DRGs, patients are billed charges (or historic price per case hospital as of May 1, 1985).

A set of length of stay "histogram", which shows pictorally, the distribution by length of stay for patients in the 9 psychiatric DRGs is indicated as Attachment C. This set of histograms is the one upon which trim points for the 468 DRGs were set. The majority of length of stay distributions are not "normal curves", they are "log-normal". That means, the distribution is shifted toward the vertical axis as below:



In most DRGs, the majority of patients are discharged in this log normal pattern. Clinical determinations were extremely important because statistical measures are only a starting point - medical practice and experience provides the true clinical picture.

B. Coding

As mentioned, ICD-9-CM codes were used to construct the 468 DRGs and these codes are universal. In a hospital, medical record professionals review each patient's hospital chart and apply the numeric ICD-9-CM codes appropriate for all disgnoses and procedures as given by the attending physician, or as documented elsewhere in the medical record.

ICD-9-CM codes were developed by an ICD-9-CM Committee under the auspices of the National Center for Health Statistics. All questions on appropriateness codes were, until March 1985, referred to that committee. There are about 450 psychiatric diagnosis codes. As of this March, questions and concerns about ICD-9-CM codes and DRG construction, are referred to HCFA's Prospective Payment Assessment Commission (ProPAC). Neither coding issues or DRG construction issues are under the authority of the New Jersey State Department of Health.

As a side note, the Council on Clinical Classification provided a Task Force for the ICD-9-CM Committee. The American Psychiatric Association is a sponsor of the Council, and 4 of its members were on the Task Force.

C. DRG Assignment

DRGs are assigned based upon ICD-9-CM codes for diagnoses and procedures, and the other variables previously mentioned. A DRG can be assigned only after the patient is discharged. Once a DRG is assigned, outlier status can be determined.

Outliers are patients atypical in terms of length of stay or resource consumption in an acute care setting. Until May 1, 1985, there were 8 outlier categories (1982-1984) which included about 30% of the acute care patients statewide. Until May 1, 1985, all outlier patients were billed charges. Regular inlier patients are billed the DRG payment rate. As of May 1, 1985, different payment mechanisms apply for outliers, and there are now 6 categories of outliers.

A description of the 8 outlier categories (1982-1984) can be found in Attachment D.

III. Payment for Psychiatric DRGs

Payment rates are calculated for psychiatric DRGs in New Jersey just as for any other DRG in acute care general hospitals. The rate is based on each hospital's historic costs, and charges and medical information for each patient. Rates for 1984 and 1985 were set on 1982 data. Rates for 1981 - 1983 were set on 1979 data.

Rates include a direct patient care portion, and an indirect portion to cover fixed costs, including uncompensated care, and capital allowances.

The rates are hospital specific and are adjusted for teaching status, labor market area, and case-mix experience. Each DRG has 91 rates for the 91 hospitals in New Jersey. Hospital-specific rates provide a cushion for individual hospital experience.

In Medicare's Prospective Payment System (PPS) psychiatric hospitals are excluded from PPS. Psychiatric units within acute care hospitals may be excluded if they petition HCFA and meet certain requirements as specified in the Federal regulations. Medicare will continue to pay for those patients on the basis of reasonable cost. If a hospital with a psychiatric unit does not petition that the unit be excluded, payment for those patients will be the "reasonable rate".

IV. Experience with Psychiatric Issues

There have been three psychiatric issues brought to the Department's attention over the past 5 years of the DRG system. The first is clinical, the second is financial, and the third is quality of care.

a. Clinical

The clinical issue is comprised of two parts - the use of ICD-9-CM codes for psychiatric diagnoses, and the grouping of those codes into certain configurations. This issue was brought to the Department's attention in 1982 by Dr. Charles Carluccio, Holy Name Hospital. His first concern was that ICD-9-CM codes did not adequately capture the nuances of psychiatric diagnoses and certain diagnoses were not properly labelled in the ICD-9-CM code book. Dr. Carluccio's second concern was that groupings of particular codes into a given DRG did not fit the physicians sense of appropriate groupings.

He was referred to the ICD-9-CM Committee with the suggestion that the psychiatry specialty societies should work with the Committee to make

ICD-9-CM more accurate. He was also referred to Yale, to make his concerns on DRG construction known.

These two issues were raised by Underwood Hospital in 1984, by a few other physicians and, again, by Dr. Carluccio in April 1985. In April, Dr. Carluccio was referred to ProPAC for both the ICD-9-CM coding issue and DRG construction issue.

Attachment E contains written correspondence from the Department to Holy Name Hospital (1982), from the Department to Dr. Carluccio (May 1985), from the Department to ProPAC (May 1985) and from ProPAC to the Department (May 1985). Dr. Willian, ProPAC, indicates that no other correspondence has been received (Dr. Willian would also have received correspondence to HCFA), and that a study is being conducted on the psychiatric DRGs. No action will be taken until the study is complete. (Telephone conversations are not included in this attachment). Therefore, the coding and construction issues must wait for resolution.

The Department routinely works with committees and groups, either within or outside of New Jersey, to solve problems brought to its attention.

b. Payment

The second issue is payment for psychiatric patients. Inlier psychiatric patients are billed a DRG rate per case. If it is necessary that patients remain in the acute care setting, adequate documentation must be present in the medical record that this patient needs acute care services. The Utilization Review Organizations (UROs) function as a quality of care arm of the Department of Health under New Jersey's DRG system. As long as it is medically necessary for the patient to be in an acute care setting and there is documentation in the medical record, the URO and hospital have

no Financial reason to "push the patient out". If the stay is over the high trim and is medically necessary, the hospital bills charges (or the high length of stay per diem as of May 1, 1985). Indigent patients will not be "pushed out" because New Jersey's system covers uncompensated care. The hospitals will receive the costs incurred for treatment of indigent psychiatric patients. Acute care services should be utilized by those patients who truly need them. Utilization of acute services by non-acute patients is costly to the patient, is not quality care and drives health care costs upward. Alternative modes of treatment should be used, where appropriate, for psychiatric patients.

Only two acute care hospitals, St. Clare's and Elizabeth General, have appealed to the Department for an adjustment to their rates because of their psychiatric case-mix. They are in the process of supplying data to the Department. Dr. Morton Friedman, recently, had written to Dr. Goldstein, Commissioner of Health, to alert him to a possible problem in decrease of psychiatric services at Overlook Hospital. Overlook has not appealed their psychiatric rates and has not indicated to the Department that there is a problem.

The hospital rate appeal mechanism is used, as is the clinical DRG appeal mechanism, to alleviate any unforeseen problems of a hospital in payment for and treatment of its own case-mix.

In private and state psychiatric hospitals, the average length of stay for psychiatric patients is 33 days. The SHARE system does not cover uncompensated care, so the burden for treating those indigent patients is picked up by certain payers.

c. Quality of Care

As mentioned, the UROs are the quality monitoring arm of the Department. They perform concurrent review on medical necessity and appropriateness of care, and perform retrospective review on outlier cases, DRG validation and special studies, as well as other functions.

Psychiatric patients in acute care hospitals are reviewed by the UROs just as are other patients. In unusual questions arise, consultant psychiatrists are called in by the UROs.

The Department has not received any patient appeals on the psychiatric DRGs. If there were a problem with DRG assignment, equity of charges or medical necessity, an appeal could be brought.

In a more general sense, one of the UROs, Metropolitan Peer Review Organization, conducted a study in 1983-1984 to address the question "Is quality of care being eroded by New Jersey's DRG System"? The results showed that any problems that existed were not due to the DRG system, but to poor planning, lack of patient education or improper treatment.

If anything, the DRG system has focussed attention on quality of care issues and has served to heighten the awareness of health care practices by physicians, insurance companies, regulators, hospitals and health care consumers. Consumers and others are more willing to question medical practice and hospital performance. Such awareness can lead to improvements in health care in New Jersey and the nation.

V. Data

Attachments F and G contain a variety of clinical and financial data on the psychiatric DRGs. Attachments F and G show that the number of patients and number of psychiatric units and beds have increased, even taking into

account a charge in the DRG groupings from 1981 to 1982. Length of stay has decreased.

The charge amounts in Attachment F-1 through F-4 are informational.

Attachment F-6 also contains informational numbers. It contains the direct patient care standard by DRG. Rates for 1984 and 1985 were set with these numbers as a basis. Only inlier patients are represented.

Attachment G contains pictoral representation of length of stay for each psychiatric DRG for 3 years. A totals page is first, then there are two graphs for each DRG. The first is a representation of the number of patients discharged by day, the second is the percent of patients discharged by day. Comparison of the two graphs, and the totals page, can give an idea of changes in discharge patterns.

A more detailed explanation of each attachment follows:

Attachments F-1 through F-4 show, by DRG, the number of inlier and outlier patients, and inlier and outlier charges, taken from the Uniform Bill-Patient Summary (UB-PS). These data are for 1980 - 1983.

Attachment F-1 shows numbers for the 26 DRG hospitals which implemented in the DRG system in 1980. About 1% of the psychiatric patients were outliers (only length of stay outliers were used).

Attachment F-2 shows 1981 numbers for all DRG hospitals. The trim points for 1981 differ from 1980, particularly in DRGs 88, Schizophrenia with psychiatric service and DRG 96, Psychosis. About 19% of the psychiatric patients were outliers.

Attachment F-3 shows 1982 numbers. This was the first year that the 468 DRGs were used. These psychiatric DRGs differed from the old psychiatric

DRGs so it is not appropriate to try to equate them exactly. There were also 8 outlier categories, and about 25% of the psychiatric patients were outliers in the 6 outlier categories indicated in the attachment.

Attachment F-4 shows 1983 numbers. The number of psychiatric patients have increased over 1982, and the percent of outlier psychiatric patients remains the same (for the 6 outlier categories).

Attachment F-5 shows utilization statistics from the Center for Health Statistics. The number of psychiatric units and number of beds has increased 1980-1984. Admissions fluctuate but have risen since 1980, as have patient days. Length of stay (for all patients, inliers and outliers) has dropped from 14.1 in 1980 to 12.6 in 1983. Occupancy has fluctuated, but dropped for 1983.

The decrease in length of stay could be due to provision of better screening services by hospitals, and the forwarding of patients to more appropriate treatment settings. It is doubtful that the decrease is due entirely to the DRG system.

Attachment F-6 shows the direct patient care (DPC) standard (average) for each peer group - major teaching, minor teaching and non-teaching hospitals. These standards are the basis for rates which will be generated. For purposes of comparison, usually the DPC standard is used because it is a number comparable across hospitals. The highest DPC standard is for DRG 430, Psychoses, with DRG 429, Organic disturbance, retardation a close second.

No indirect costs are included in this attachment. The final rates will be hospital-specific.

Attachment G contains one page of totals for patients by DRG by year, and average length of stay by DRG by year. A comparison of these numbers with the two graphs indicates changes in discharge trends 1979 to 1982, to 1983.

DRG 424, mental disorder with any operating room procedure. The number of patients has increased over the period (1979-1983) and average length of stay has dropped. As evident from the graphs, there is a wide assortment of patient discharge patterns. This DRG is a clinical outlier because of the disparity between patients.

DRG 425, Acute, adjustment reactions and psychosocial dysfunction. The number of patients and length of stay decreased over the period. Discharge patterns remain similar in terms of number and percent of patients discharged on each day.

DRG 426, Neuroses with principal diagnosis of depressive neuroses. Both number of patients and length of stay have decreased 1979 to 1983. The discharge patterns have changed slightly. In 1979, more patients were discharged after 8 days than in 1982 or 1983. The pattern (or "peak") has shifted slightly toward earlier discharge.

DRG 427, Neuroses, without principal diagnosis of depressive neuroses. The number of patients has increased and length of stay has decreased by a small amount. The patterns of discharge are similar in 1979, 1982 and 1983.

DRG 428, Disorders of personality or impulse control. Both number of patients and length of stay have increased 1979 to 1983. This can be seen, especially in the Number of Cases graph. The line for 1983, for most of the graph, remains above the 1979 and 1982 lines.

DRG 429, Organic disturbances, mental retardation. Both number of patients and length of stay have decreased. The pattern of discharge remained similar from 1979 through 1983.

DRG 430, Psychoses. The number of patients in this DRG has increased considerably. Length of stay has increased slightly. The discharge pattern remained similar from 1979 through 1983. The Number of Cases graph shows the increase in patients quite dramatically.

DRG 431, Childhood disorders. The number of cases has increased and length of stay has doubled. The discharge patterns are unusual in that there is a significant number of patients in and out the same day.

Both DRGs 430 and 431 warrant further investigation.

DRG 432, Other diagnoses of mental disorder. This is another clinical DRG. The number of patients and length of stay have both decreased from 1979 through 1983. Given the type of cases in this DRG, many sexual dysfunctions, the patients may have shifted to other modes of treatment.

The data presented in Attachments F and G show utilization trends in the psychiatric DRGs. Overall, there is an increase in patients, psychiatric units and beds. Specific DRG patterns may vary and specific hospital patterns may vary.

Data should be monitored by the Department, hospitals and payers to determine any shifts in patterns that could indicate changes in medical practice or other changes. Any possible problems are found sooner if data is monitored on a continuing basis.

Hospitals have not yet been able to provide "hard data" to substantiate allegations that payment for psychiatric DRGs is inadequate,

and that inappropriate early discharges are occurring because of financial incentives in the DRG system.

VI. Present Efforts

A. Department of Health and Department of Human Services Interaction

The Departments of Health and of Human Services have engaged in several cooperative efforts. First, the two Departments are in agreement that chronic psychiatric patients, who require an acute level of care, should be admitted into an acute care facility for the appropriate time it takes to stabilize that patient. A reduction in length of stay in the acute setting is consistent with the desire to return the patient to the least restrictive setting as soon as possible, as should occur in a unified service system. There are also strong discharge planning links in a unified system.

Second, the two Departments have developed a joint State plan.

Third, the two Departments have cooperated on joint, draft licensing standards for the behavioral services - alcohol, drug and mental health services.

Fourth, an interdepartmental agreement is now being finalized to provide inpatient psychiatric services for involuntarily committed patients in general hospitals on a regional basis.

The Department of Health and Department of Human Services anticipate continued cooperative efforts to provide a unified system of psychiatric service throughout the State of New Jersey.

B. Interaction within New Jersey

The Department of Health continues to work with hospitals, physicians and other parties to solve any verified problems that are under Departmental authority. At the present,

the Department is working with Elizabeth General and St. Clare's Hospital to determine if children and involuntary patients cost more to treat than voluntary adult patients. As mentioned, both hospitals will be supplying data to support this contention.

The Department cannot move to affect any changes based upon unsupported allegations - it must have "hard data". That is one reason why the Department has always welcomed the input, comments and suggestions of physicians, psychiatrists and other representatives of the health care industry. A health care system cannot be administered in a vacuum and those of us involved in the DRG system have a history of strong interaction and cooperation with the health care industry. The goal is to provide quality health care in the most efficient manner to all segments of society.

The Department also continues to monitor the data collected from hospitals and other groups to determine trends and changes in the provision of care to psychiatric patients.

C. Interaction with Groups Outside of New Jersey

The Department continues to refer psychiatrists, society members and other interested parties to groups which have authority over specific concerns such as appropriateness of ICD-9-CM codes for psychiatric diagnoses and construction of Diagnosis Related Groups. The Department itself also continues to bring such concerns to the attention of appropriate groups.

Since ProPAC has been charged (in March 1985) with studying the coding and construction issues, the Department will continue to work closely with ProPAC to follow up on areas of concern from New Jersey. Dr. Willian and other members of the Commission have been very interested in and appreciative of New Jersey's experiences in many areas of the

DRG system. I strongly urge individual psychiatrists and specialty societies to voice their concerns to ProPAC.

The Department will also keep abreast of the HCFA commissioned study on psychiatric DRGs. It may be that there were simply not enough acute care psychiatric patient records in the data base from which the DRGs were constructed to show significant differences in patients at a level more refined than the present psychiatric DRGs. Hopefully, HCFA's commissioned study will address possible reconstruction of the psychiatric DRGs or provide some other mutually acceptable solution to the issues raised about the DRGs themselves.

VII. Summary and Recommendations

In summary, the Department of Health has had a history of working with New Jersey's health care industry to develop, implement and refine its DRG system. There has been considerable physician input into various aspects of the system, and psychiatrist input into development of the psychiatric DRGs.

The Department has been working, and will continue to work with the health care industry to find and solve valid problems with the psychiatric DRGs. Issues not under Departmental authority, such as coding and DRG construction, will continue to be brought to the attention of the proper groups. Issues under Departmental authority will be reviewed, discussed and resolved through interaction with the health care industry.

The Department will continue to monitor data to determine trends, such as in length of stay or case-mix, and quality of care issues. The Department of Health will continue to work cooperatively with the Department of Human Services to have an integrated system of psychiatric care throughout

the spectrum of services.

The Department of Health recommends waiting until HCFA's study on psychiatric DRGs is complete. If changes to DRG coding or construction are made, the Department will adopt those changes for use in New Jersey. The Department also recommends close interaction with ProPAC during this time period for information flow to and from the federal government.

The Department of Health also recommends no change in payment mechanism for psychiatric patients in acute care general hospitals at this time. A new outlier methodology has just gone into effect (May 1, 1985) and the results of that change are uncertain. Based upon the data, a general statewide problem is not apparent. However, individual hospitals may have problems and if so should work with their rate analyst to determine the best course of action.

As always, the Department of Health welcomes and encourages comments and statistical evidence that point to constructive change. We look forward to continued cooperative efforts with the health care industry. We will be happy to provide any other information to this Committee or to discuss this issue further.

ATTACHMENT A

TREE DIAGRAMS OF,

SPECIFIC DIAGNOSES, AND ICD-9-CM CODES

INCLUDED IN EACH DRG IN MDC 19 -

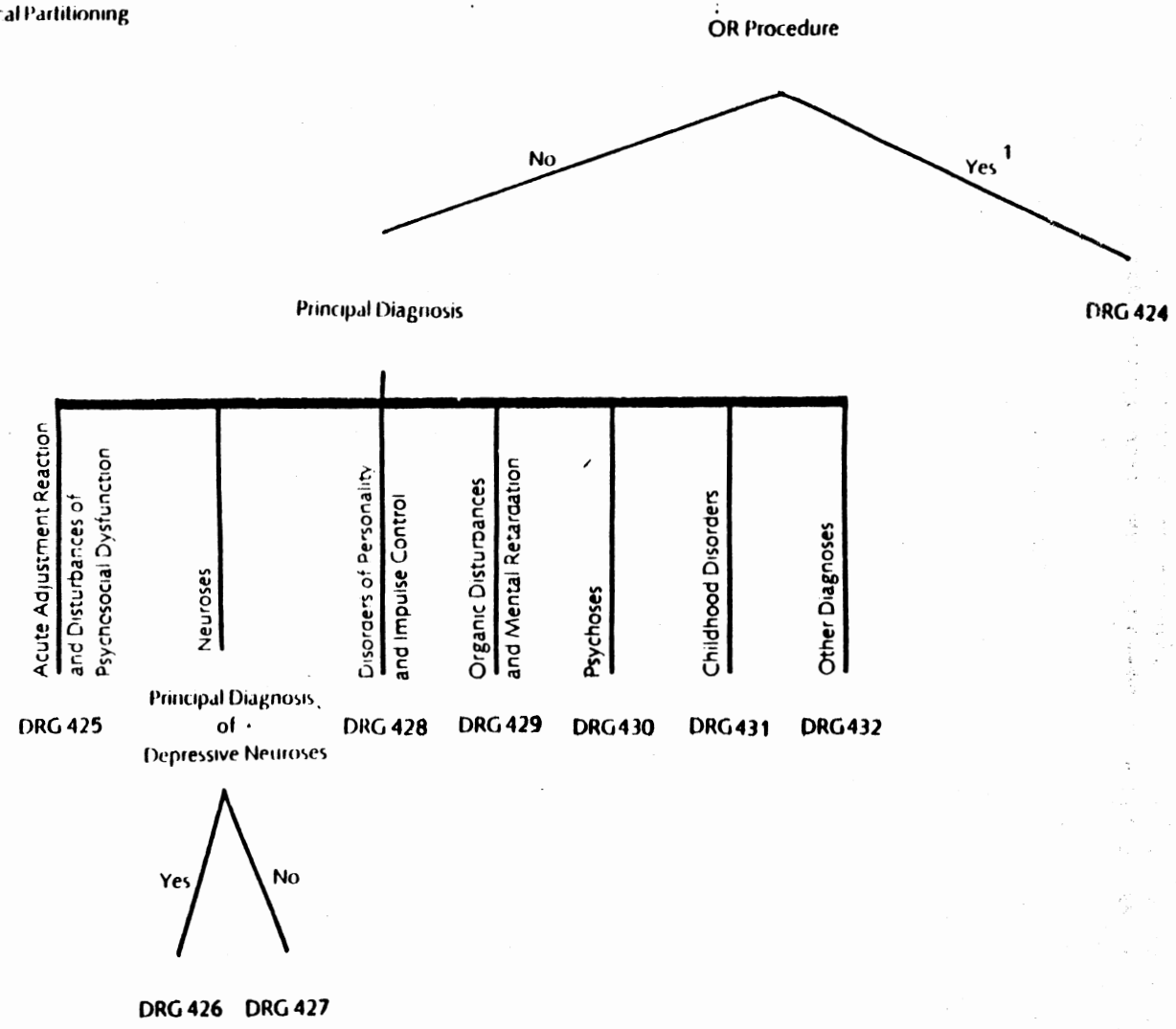
MENTAL DISEASES AND DISORDERS

MDC 19

MENTAL DISEASES AND DISORDERS

Figure 19
Major Diagnostic Category 19:
Mental Diseases and Disorders

Surgical and Medical Partitioning



1 All operating room procedure codes are allowable

MDC 19,MENTAL DISEASES & DISORDERS

V7101	OBSV-ADULT ANTISOC BEHAV
V7102	OBSV-ADOLESC ANTISOC BEH
V7109	OBSERV-MENTAL COND NEC
2900	SENILE DEMENTIA UNCOMP
29010	PRESENILE DEMENTIA
29011	PRESENILE DELIRIUM
29012	PRESENILE DELUSION
29013	PRESENILE DEPRESSION
29020	SENILE DELUSION
29021	SENILE DEPRESSIVE
2903	SENILE DELIRIUM
29040	ARTERIOSCLER DEMENT NOS
29041	ARTERIOSCLER DELIRIUM
29042	ARTERIOSCLER DELUSION
29043	ARTERIOSCLER DEPRESSIVE
2908	SENILE PSYCHOSIS NEC
2909	SENILE PSYCHOT COND NOS
2930	ACUTE DELIRIUM
2931	SUBACUTE DELIRIUM
29381	ORGANIC DELUSIONAL SYND
29382	ORGANIC HALLUCINOSIS SYN
29383	ORGANIC AFFECTIVE SYND
29389	TRANSIENT ORG MENTAL NEC
2939	TRANSIENT ORG MENTAL NOS
2940	AMNESTIC SYNDROME
2941	DEMENTIA IN OTH DISEASES
2948	ORGANIC BRAIN SYND NEC
2949	ORGANIC BRAIN SYND NOS
29500	SIMPL SCHIZOPHREN-UNSPEC
29501	SIMPL SCHIZOPHREN-SUBCHR
29502	SIMPLE SCHIZOPHREN-CHR
29503	SIMP SCHIZ-SUBCHR/EXACER
29504	SIMPL SCHIZO-CHR/EXACERB
29505	SIMPL SCHIZOPHREN-REMISS
29510	HEBEPHRENIA-UNSPEC
29511	HEBEPHRENIA-SUBCHRONIC
29512	HEBEPHRENIA-CHRONIC
29513	HEBEPHREN-SUBCHR/EXACERB
29514	HEBEPHRENIA-CHR/EXACERB
29515	HEBEPHRENIA-REMISSION
29520	CATATONIA-UNSPEC
29521	CATATONIA-SUBCHRONIC
29522	CATATONIA-CHRONIC
29523	CATATONIA-SUBCHR/EXACERB
29524	CATATONIA-CHR/EXACERB
29525	CATATONIA-REMISSION
29530	PARANOID SCHIZO-UNSPEC
29531	PARANOID SCHIZO-SUBCHR
29532	PARANOID SCHIZO-CHRONIC
29533	PARAN SCHIZO-SUBCHR/EXAC
29534	PARAN SCHIZO-CHR/EXACERB
29535	PARANOID SCHIZO-REMISS
29540	AC SCHIZOPHRENIA-UNSPEC
29541	AC SCHIZOPHRENIA-SUBCHR
29542	AC SCHIZOPHRENIA-CHR
29543	AC SCHIZO-SUBCHR/EXACERB
29544	AC SCHIZOPHR-CHR/EXACERB
29545	AC SCHIZOPHRENIA-REMISS
29550	LATENT SCHIZOPHREN-UNSP
29551	LAT SCHIZOPHREN-SUBCHR
29552	LATENT SCHIZOPHREN-CHR
29553	LAT SCHIZO-SUBCHR/EXACER
29554	LATENT SCHIZO-CHR/EXACER
29555	LAT SCHIZOPHREN-REMISS
29560	RESID SCHIZOPHREN-UNSP
29561	RESID SCHIZOPHREN-SUBCHR
29562	RESIDUAL SCHIZOPHREN-CHR
29563	RESID SCHIZO-SUBCHR/EXAC
29564	RESID SCHIZO-CHR/EXACERB
29565	RESID SCHIZOPHREN-REMISS
29570	SCHIZOAFFECTIVE-UNSPEC
29571	SCHIZOAFFECTIVE-SUBCHR
29572	SCHIZOAFFECTIVE-CHRONIC
29573	SCHIZOAFF-SUBCHR/EXACER
29574	SCHIZOAFFECT-CHR/EXACER
29575	SCHIZOAFFECTIVE-REMISS
29580	SCHIZOPHRENIA NEC-UNSPEC
29581	SCHIZOPHRENIA NEC-SUBCHR
29582	SCHIZOPHRENIA NEC-CHR
29583	SCHIZO NEC-SUBCHR/EXACER
29584	SCHIZO NEC-CHR/EXACERB
29585	SCHIZOPHRENIA NEC-REMISS
29590	SCHIZOPHRENIA NOS-UNSPEC
29591	SCHIZOPHRENIA NOS-SUBCHR
29592	SCHIZOPHRENIA NOS-CHR
29593	SCHIZO NOS-SUBCHR/EXACER
29594	SCHIZO NOS-CHR/EXACERB
29595	SCHIZOPHRENIA NOS-REMISS
29600	MANIC DISORDER-UNSPEC
29601	MANIC DISORDER-MILD
29602	MANIC DISORDER-MOD
29603	MANIC DISORDER-SEVERE
29604	MANIC DIS-SEVERE W PSYCH
29605	MANIC DIS-PARTIAL REMISS
29606	MANIC DIS-FULL REMISSION
29610	RECUR MANIC DIS-UNSPEC
29611	RECUR MANIC DIS-MILD
29612	RECUR MANIC DIS-MOD
29613	RECUR MANIC DIS-SEVERE
29614	RECUR MANIC-SEV W PSYCHO
29615	RECUR MANIC-PART REMISS
29616	RECUR MANIC-FULL REMISS
29620	DEPRESS PSYCHOSIS-UNSPEC
29621	DEPRESS PSYCHOSIS-MILD

29622	DEPRESSIVE PSYCHOSIS-MOD
29623	DEPRESS PSYCHOSIS-SEVERE
29624	DEPR PSYCHOS-SEV W PSYCH
29625	DEPR PSYCHOS-PART REMISS
29626	DEPR PSYCHOS-FULL REMISS
29630	RECURR DEPR PSYCHOS-UNSP
29631	RECURR DEPR PSYCHOS-MILD
29632	RECURR DEPR PSYCHOS-MOD
29633	RECUR DEPR PSYCH-SEVERE
29634	REC DEPR PSYCH-PSYCHOTIC
29635	RECUR DEPR PSYC-PART REM
296.6	RECUR DEP[illegible]
296.0	BIPOL AFF, MANIC-UNSPEC
29641	BIPOLAR AFF, MANIC-MILD
29642	BIPOLAR AFFEC, MANIC-MOD
29643	BIPOL AFF, MANIC-SEVERE
29644	BIPOL MANIC-SEV W PSYCH
29645	BIPOL AFF MANIC-PART REM
29646	BIPOL AFF MANIC-FULL REM
29650	BIPOLAR AFF, DEPR-UNSPEC
29651	BIPOLAR AFFEC, DEPR-MILD
29652	BIPOLAR AFFEC, DEPR-MOD
29653	BIPOL AFF, DEPR-SEVERE
29654	BIPOL DEPR-SEV W PSYCH
29655	BIPOL AFF DEPR-PART REM
29656	BIPOL AFF DEPR-FULL REM
29660	BIPOL AFF, MIXED-UNSPEC
29661	BIPOLAR AFF, MIXED-MILD
29662	BIPOLAR AFFEC, MIXED-MOD
29663	BIPOL AFF, MIXED-SEVERE
29664	BIPOL MIXED-SEV W PSYCH
29665	BIPOL AFF, MIX-PART REM
29666	BIPOL AFF, MIX-FULL REM
2967	BIPOLAR AFFECTIVE NOS
29680	MANIC-DEPRESSIVE NOS
29681	ATYPICAL MANIC DISORDER
29682	ATYPICAL DEPRESSIVE DIS
29689	MANIC-DEPRESSIVE NEC
29690	AFFECTIVE PSYCHOSIS NOS
29699	AFFECTIVE PSYCHOSES NEC
2970	PARANOID STATE, SIMPLE
2971	PARANOIA
2972	PARAPHRENIA
2973	SHARED PARANOID DISORDER
2978	PARANOID STATES NEC
2979	PARANOID STATE NOS
2980	REACT DEPRESS PSYCHOSIS
2981	EXCITATIV TYPE PSYCHOSIS
2982	REACTIVE CONFUSION
2983	ACUTE PARANOID REACTION
2984	PSYCHOGEN PARANOID PSYCH
2988	REACT PSYCHOSIS NEC/NOS
2989	PSYCHOSIS NOS
29900	INFANTILE AUTISM-ACTIVE
29901	INFANTILE AUTISM-RESID
29910	DISINTEGR PSYCH-ACTIVE
29911	DISINTEGR PSYCH-RESIDUAL
29980	CHILD PSYCHOS NEC-ACTIVE
29981	CHILD PSYCHOS NEC-RESID
29990	CHILD PSYCHOS NOS-ACTIVE
29991	CHILD PSYCHOS NOS-RESID
30000	ANXIETY STATE NOS
30001	PANIC DISORDER
30002	GENERALIZED ANXIETY DIS
30009	ANXIETY STATE NEC
3[illegible]0	H[illegible]STERIA NOS
30011	CONVERSION DISORDER
30012	PSYCHOGENIC AMNESIA
30013	PSYCHOGENIC FUGUE
30014	MULTIPLE PERSONALITY
30015	DISSOCIATIVE REACT NOS
30016	FACTITIOUS ILL W SYMPTOM
30019	FACTITIOUS ILL NEC/NOS
30020	PHOBIA NOS
30021	AGORAPHOBIA WITH PANIC
30022	AGORAPHOBIA W/O PANIC
30023	SOCIAL PHOBIA
30029	ISOLATED PHOBIAS NEC
3003	OBSESSIVE-COMPULSIVE DIS
3004	NEUROTIC DEPRESSION
3005	NEURASTHENIA
3006	DEPERSONALIZATION SYND
3007	HYPOCHONDRIASIS
30081	SOMATIZATION DISORDER
30089	NEUROTIC DISORDERS NEC
3009	NEUROTIC DISORDER NOS
3010	PARANOID PERSONALITY
30110	AFFECTIV PERSONALITY NOS
30111	CHRONIC HYPOMANIC PERSON
30112	CHR DEPRESSIVE PERSON
30113	CYCLOTHYMIC DISORDER
30120	SCHIZOID PERSONALITY NOS
30121	INTROVERTED PERSONALITY
30122	SCHIZOTYPAL PERSONALITY
3013	EXPLOSIVE PERSONALITY
3014	COMPULSIVE PERSONALITY
30150	HISTRIONIC PERSON NOS
30151	CHR FACTITIOUS ILLNESS
30159	HISTRIONIC PERSON NEC
3016	DEPENDENT PERSONALITY
3017	ANTISOCIAL PERSONALITY
30181	NARCISSISTIC PERSONALITY
30182	AVOIDANT PERSONALITY
30183	BORDERLINE PERSONALITY
30184	PASSIVE-AGGRESSIV PERSON
30189	PERSONALITY DISORDER NEC
3019	PERSONALITY DISORDER NOS
3020	HOMOSEXUALITY

3021	ZOOPHILIA
3022	PEDOPHILIA
3023	TRANSVESTISM
3024	EXHIBITIONISM
30250	TRANS-SEXUALISM NOS
30251	TRANS-SEXUALISM, ASEXUAL
30252	TRANS-SEXUAL, HOMOSEXUAL
30253	TRANS-SEX, HETEROSEXUAL
3026	PSYCHOSEX IDENTITY DIS
30270	PSYCHOSEXUAL DYSFUNC NOS
30271	INHIBITED SEXUAL DESIRE
30272	INHIBITED SEX EXCITEMENT
30273	INHIBITED FEMALE ORGASM
30274	INHIBITED MALE ORGASM
30275	PREMATURE EJACULATION
30276	FUNCTIONAL DYSPAREUNIA
30279	PSYCHOSEXUAL DYSFUNC NEC
30281	FETISHISM
30282	VOYEURISM
30283	SEXUAL MASOCHISM
30284	SEXUAL SADISM
30285	GENDER IDENT DIS, ADULT
30289	PSYCHOSEXUAL DIS NEC
3029	PSYCHOSEXUAL DIS NOS
3067	PSYCHOGENIC SENSORY DIS
3068	PSYCHOGENIC DISORDER NEC
3069	PSYCHOGENIC DISORDER NOS
3070	STAMMERING STUTTERING
3071	ANOREXIA NERVOSA
3073	STEREOTYPED MOVEMENTS
30740	NONORGANIC SLEEP DIS NOS
30741	TRANSIENT INSOMNIA
30742	PERSISTENT INSOMNIA
30743	TRANSIENT HYPERSOMNIA
30744	PERSISTENT HYPERSOMNIA
30745	DISRUPT SLEEP-WAKE CYCLE
30746	SOMNAMBULISM/NGHT TERROR
30747	SLEEP STAGE DYSFUNC NEC
30748	REPETIT SLEEP INTRUSION
30749	NONORGANIC SLEEP DIS NEC
30750	EATING DISORDER NOS
30751	BULIMIA
30752	PICA
30753	PSYCHOGENIC RUMINATION
30754	PSYCHOGENIC VOMITING
30759	EATING DISORDER NEC
3076	ENURESIS
3077	ENCOPRESIS
30780	PSYCHOGENIC PAIN NOS
30789	PSYCHOGENIC PAIN NEC
3079	SPECIAL SYMPTOM NEC/NOS
3080	STRESS REACT, EMOTIONAL
3081	STRESS REACTION, FUGUE
3082	STRESS REACT, PSYCHOMOT
3083	ACUTE STRESS REACT NEC
3084	STRESS REACT, MIXED DIS
3089	ACUTE STRESS REACT NOS
3090	BRIEF DEPRESSIVE REACT
3091	PROLONG DEPRESSIVE REACT
30921	SEPARATION ANXIETY
30922	EMANCIPATION DISORDER
30923	ACADEMIC/WORK INHIBITION
30924	ADJ REACT-ANXIOUS MOOD
30928	ADJ REACT-MIXED EMOTION
30929	ADJ REACT-EMOTION NEC
3093	ADJUST REACT-CONDUCT DIS
3094	ADJ REACT-EMOTION/CONDUC
30981	PROLONG POSTTRAUM STRESS
30982	ADJUST REACT-PHYS SYMPT
30983	ADJUST REACT-WITHDRAWAL
30989	ADJUSTMENT REACTION NEC
3099	ADJUSTMENT REACTION NOS
3100	FRONTAL LOBE SYNDROME
3101	ORGANIC PERSONALITY SYND
3108	NONPSYCHOT BRAIN SYN NEC
3109	NONPSYCHOT BRAIN SYN NOS
311	DEPRESSIVE DISORDER NEC
31200	UNSOCIAL AGGRESS-UNSPEC
31201	UNSOCIAL AGGRESSION-MILD
31202	UNSOCIAL AGGRESSION-MOD
31203	UNSOCIAL AGGRESS-SEVERE
31210	UNSOCIAL UNAGGRESS-UNSP
31211	UNSOCIAL UNAGGRESS-MILD
31212	UNSOCIAL UNAGGRESS-MOD
31213	UNSOCIAL UNAGGR-SEVERE
31220	SOCIAL CONDUCT DIS-UNSP
31221	SOCIAL CONDUCT DIS-MILD
31222	SOCIAL CONDUCT DIS-MOD
31223	SOCIAL CONDUCT DIS-SEV
31230	IMPULSE CONTROL DIS NOS
31231	PATHOLOGICAL GAMBLING
31232	KLEPTOMANIA
31233	PYROMANIA
31234	INTERMITT EXPLOSIVE DIS
31235	ISOLATED EXPLOSIVE DIS
31239	IMPULSE CONTROL DIS NEC
3124	MIX DIS CONDUCT/EMOTION
3128	OTHER CONDUCT DISTURB
3129	CONDUCT DISTURBANCE NOS
3130	OVERANXIOUS DISORDER
3131	MISERY UNHAPPINESS DIS
31321	SHYNESS DISORDER-CHILD
31322	INTROVERTED DIS-CHILD
31323	ELECTIVE MUTISM
3133	RELATIONSHIP PROBLEMS
31381	OPPOSITIONAL DISORDER
31382	IDENTITY DISORDER
31383	ACADEMIC UNDERACHIEVMENT

31389	EMOTIONAL DIS CHILD NEC	317	MILD MENTAL RETARDATION
3139	EMOTIONAL DIS CHILD NOS	3180	MOD MENTAL RETARDATION
31400	ATTN DEFIC NONHYPERACT	3181	SEVERE MENTAL RETARDAT
31401	ATTN DEFICIT W HYPERACT	3182	PROFOUND MENTAL RETARDAT
3141	HYPERKINET W DEVEL DELAY	319	MENTAL RETARDATION NOS
3142	HYPERKINETIC CONDUCT DIS	7580	DOWN'S SYNDROME
3148	OTHER HYPERKINETIC SYND	7581	PATAU'S SYNDROME
3149	HYPERKINETIC SYND NOS	7582	EDWARDS' SYNDROME
31500	READING DISORDER NOS	7801	HALLUCINATIONS
31501	ALEXIA	78050	SLEEP DISTURBANCE NOS
31502	DEVELOPMENTAL DYSLEXIA	78052	INSOMNIA NEC
31509	READING DISORDER NEC	78054	HYPERSOMNIA NEC
3151	ARITHMETICAL DISORDER	78055	IRREG SLEEP-WAKE RHY NOS
3152	OTH LEARNING DIFFICULTY	78056	SLEEP STAGE DYSFUNCTIONS
31531	DEVELOPMENT LANGUAGE DIS	78059	SLEEP DISTURBANCES NEC
31539	SPEECH/LANGUAGE DIS NEC	78460	SYMBOLIC DYSFUNCTION NOS
3154	COORDINATION DISORDER	78461	ALEXIA AND DYSLEXIA
3155	MIXED DEVELOPMENT DIS	78469	SYMBOLIC DYSFUNCTION NEC
3158	DEVELOPMENT DELAYS NEC	797	SENILITY W/O PSYCHOSIS
3159	DEVELOPMENT DELAY NOS	7992	NERVOUSNESS
316	PSYCHIC FACTOR W OTH DIS		

MDC 19 DEFINITIONS OF DRGS

MDC 19,MENTAL DISEASES & DISORDERS

DRG 424,MDC 19P,O.R. PROCEDURES W PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS

ANY OPERATING ROOM PROCEDURE

DRG 425,MDC 19M,ACUTE ADJUST REACT & DISTURB OF PSYCHOSOCIAL DYSFUNCTION

PRINCIPAL DIAGNOSIS

V7101	OBSV-ADULT ANTISOC BEHAV	30015	DISSOCIATIVE REACT NOS
V7102	OBSV-ADOLESC ANTISOC BEH	30016	FACTITIOUS ILL W SYMPTOM
2930	ACUTE DELIRIUM	30019	FACTITIOUS ILL NEC/NOS
2931	SUBACUTE DELIRIUM	3009	NEUROTIC DISORDER NOS
2939	TRANSIENT ORG MENTAL NOS	3080	STRESS REACT, EMOTIONAL
30000	ANXIETY STATE NOS	3081	STRESS REACTION, FUGUE
30001	PANIC DISORDER	3082	STRESS REACT, PSYCHOMOT
30002	GENERALIZED ANXIETY DIS	3083	ACUTE STRESS REACT NEC
30009	ANXIETY STATE NEC	3084	STRESS REACT, MIXED DIS
30010	HYSTERIA NOS	3089	ACUTE STRESS REACT NOS
30011	CONVERSION DISORDER	7801	HALLUCINATIONS
30012	PSYCHOGENIC AMNESIA	7992	NERVOUSNESS
30013	PSYCHOGENIC FUGUE		

DRG 426,MDC 19M,DEPRESSIVE NEUROSES

PRINCIPAL DIAGNOSIS

3004	NEUROTIC DEPRESSION	3091	PROLONG DEPRESSIVE REACT
30112	CHR DEPRESSIVE PERSON	311	DEPRESSIVE DISORDER NEC
3090	BRIEF DEPRESSIVE REACT		

DRG 427,MDC 19M,NEUROSES EXCEPT DEPRESSIVE

PRINCIPAL DIAGNOSIS

30020	PHOBIA NOS	30753	PSYCHOGENIC RUMINATION
30021	AGORAPHOBIA WITH PANIC	30754	PSYCHOGENIC VOMITING
30022	AGORAPHOBIA W/O PANIC	30780	PSYCHOGENIC PAIN NOS
30023	SOCIAL PHOBIA	30789	PSYCHOGENIC PAIN NEC
30029	ISOLATED PHOBIAS NEC	30921	SEPARATION ANXIETY
3003	OBSESSIVE-COMPULSIVE DIS	30922	EMANCIPATION DISORDER
3005	NEURASTHENIA	30923	ACADEMIC/WORK INHIBITION
3006	DEPERSONALIZATION SYND	30924	ADJ REACT-ANXIOUS MOOD
3007	HYPOCHONDRIASIS	30928	ADJ REACT-MIXED EMOTION
30081	SOMATIZATION DISORDER	30929	ADJ REACT-EMOTION NEC
30089	NEUROTIC DISORDERS NEC	3093	ADJUST REACT-CONDUCT DIS
3067	PSYCHOGENIC SENSORY DIS	3094	ADJ REACT-EMOTION/CONDUC
3069	PSYCHOGENIC DISORDER NOS	30981	PROLONG POSTTRAUM STRESS

30982	ADJUST REACT-PHYS SYMPT	3099	ADJUSTMENT REACTION NOS
30983	ADJUST REACT-WITHDRAWAL	3130	OVERANXIOUS DISORDER
30989	ADJUSTMENT REACTION NEC	3131	MISERY UNHAPPINESS DIS

DRG 428,MDC 19M,DISORDERS OF PERSONALITY & IMPULSE CONTROL

PRINCIPAL DIAGNOSIS

30014	MULTIPLE PERSONALITY	3017	ANTISOCIAL PERSONALITY
3010	PARANOID PERSONALITY	30181	NARCISSISTIC PERSONALITY
30110	AFFECTIV PERSONALITY NOS	30182	AVOIDANT PERSONALITY
30111	CHRONIC HYPOMANIC PERSON	30183	BORDERLINE PERSONALITY
30113	CYCLOTHYMIC DISORDER	30184	PASSIVE-AGGRESSIV PERSON
30120	SCHIZOID PERSONALITY NOS	30189	PERSONALITY DISORDER NEC
30121	INTROVERTED PERSONALITY	3019	PERSONALITY DISORDER NOS
30122	SCHIZOTYPAL PERSONALITY	3071	ANOREXIA NERVOSA
3013	EXPLOSIVE PERSONALITY	31231	PATHOLOGICAL GAMBLING
3014	COMPULSIVE PERSONALITY	31232	KLEPTOMANIA
30150	HISTRIONIC PERSON NOS	31234	INTERMITT EXPLOSIVE DIS
30151	CHR FACTITIOUS ILLNESS	31235	ISOLATED EXPLOSIVE DIS
30159	HISTRIONIC PERSON NEC	31239	IMPULSE CONTROL DIS NEC
3016	DEPENDENT PERSONALITY		

DRG 429,MDC 19M,ORGANIC DISTURBANCES & MENTAL RETARDATION

PRINCIPAL DIAGNOSIS

2900	SENILE DEMENTIA UNCOMP	2949	ORGANIC BRAIN SYND NOS
29010	PRESENILE DEMENTIA	29900	INFANTILE AUTISM-ACTIVE
29011	PRESENILE DELIRIUM	29901	INFANTILE AUTISM-RESID
29012	PRESENILE DELUSION	29910	DISINTEGR PSYCH-ACTIVE
29013	PRESENILE DEPRESSION	29911	DISINTEGR PSYCH-RESIDUAL
29020	SENILE DELUSION	3079	SPECIAL SYMPTOM NEC/NOS
29021	SENILE DEPRESSIVE	3100	FRONTAL LOBE SYNDROME
2903	SENILE DELIRIUM	3101	ORGANIC PERSONALITY SYND
29040	ARTERIOSCLER DEMENT NOS	3108	NONPSYCHOT BRAIN SYN NEC
29041	ARTERIOSCLER DELIRIUM	3109	NONPSYCHOT BRAIN SYN NOS
29042	ARTERIOSCLER DELUSION	316	PSYCHIC FACTOR W OTH DIS
29043	ARTERIOSCLER DEPRESSIVE	317	MILD MENTAL RETARDATION
2908	SENILE PSYCHOSIS NEC	3180	MOD MENTAL RETARDATION
2909	SENILE PSYCHOT COND NOS	3181	SEVERE MENTAL RETARDAT
29381	ORGANIC DELUSIONAL SYND	3182	PROFOUND MENTAL RETARDAT
29382	ORGANIC HALLUCINOSIS SYN	319	MENTAL RETARDATION NOS
29383	ORGANIC AFFECTIVE SYND	7580	DOWN'S SYNDROME
29389	TRANSIENT ORG MENTAL NEC	7581	PATAU'S SYNDROME
2940	AMNESTIC SYNDROME	7582	EDWARDS' SYNDROME
2941	DEMENTIA IN OTH DISEASES	797	SENILITY W/O PSYCHOSIS
2948	ORGANIC BRAIN SYND NEC		

MDC 19 DEFINITIONS OF DRGS

MDC 19,MENTAL DISEASES & DISORDERS

DRG 424,MDC 19P,O.R. PROCEDURES W PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS

ANY OPERATING ROOM PROCEDURE

DRG 425,MDC 19M,ACUTE ADJUST REACT & DISTURB OF PSYCHOSOCIAL DYSFUNCTION

PRINCIPAL DIAGNOSIS

V7101	OBSV-ADULT ANTISOC BEHAV	30015	DISSOCIATIVE REACT NOS
V7102	OBSV-ADOLESC ANTISOC BEH	30016	FACTITIOUS ILL W SYMPTOM
2930	ACUTE DELIRIUM	30019	FACTITIOUS ILL NEC/NOS
2931	SUBACUTE DELIRIUM	3009	NEUROTIC DISORDER NOS
2939	TRANSIENT ORG MENTAL NOS	3080	STRESS REACT, EMOTIONAL
30000	ANXIETY STATE NOS	3081	STRESS REACTION, FUGUE
30001	PANIC DISORDER	3082	STRESS REACT, PSYCHOMOT
30002	GENERALIZED ANXIETY DIS	3083	ACUTE STRESS REACT NEC
30009	ANXIETY STATE NEC	3084	STRESS REACT, MIXED DIS
30010	HYSTERIA NOS	3089	ACUTE STRESS REACT NOS
30011	CONVERSION DISORDER	7801	HALLUCINATIONS
30012	PSYCHOGENIC AMNESIA	7992	NERVOUSNESS
30013	PSYCHOGENIC FUGUE		

DRG 426,MDC 19M,DEPRESSIVE NEUROSES

PRINCIPAL DIAGNOSIS

3004	NEUROTIC DEPRESSION	3091	PROLONG DEPRESSIVE REACT
30112	CHR DEPRESSIVE PERSON	311	DEPRESSIVE DISORDER NEC
3090	BRIEF DEPRESSIVE REACT		

DRG 427,MDC 19M,NEUROSES EXCEPT DEPRESSIVE

PRINCIPAL DIAGNOSIS

30020	PHOBIA NOS	30753	PSYCHOGENIC RUMINATION
30021	AGORAPHOBIA WITH PANIC	30754	PSYCHOGENIC VOMITING
30022	AGORAPHOBIA W/O PANIC	30780	PSYCHOGENIC PAIN NOS
30023	SOCIAL PHOBIA	30789	PSYCHOGENIC PAIN NEC
30029	ISOLATED PHOBIAS NEC	30921	SEPARATION ANXIETY
3003	OBSESSIVE-COMPULSIVE DIS	30922	EMANCIPATION DISORDER
3005	NEURASTHENIA	30923	ACADEMIC/WORK INHIBITION
3006	DEPERSONALIZATION SYND	30924	ADJ REACT-ANXIOUS MOOD
3007	HYPOCHONDRIASIS	30928	ADJ REACT-MIXED EMOTION
30081	SOMATIZATION DISORDER	30929	ADJ REACT-EMOTION NEC
30089	NEUROTIC DISORDERS NEC	3093	ADJUST REACT-CONDUCT DIS
3067	PSYCHOGENIC SENSORY DIS	3094	ADJ REACT-EMOTION/CONDUC
3069	PSYCHOGENIC DISORDER NOS	30981	PROLONG POSTTRAUM STRESS

30982	ADJUST REACT-PHYS SYMPT	3099	ADJUSTMENT REACTION NOS
30983	ADJUST REACT-WITHDRAWAL	3130	OVERANXIOUS DISORDER
30989	ADJUSTMENT REACTION NEC	3131	MISERY UNHAPPINESS DIS

DRG 428,MDC 19M,DISORDERS OF PERSONALITY & IMPULSE CONTROL

PRINCIPAL DIAGNOSIS

30014	MULTIPLE PERSONALITY	3017	ANTISOCIAL PERSONALITY
3010	PARANOID PERSONALITY	30181	NARCISSISTIC PERSONALITY
30110	AFFECTIV PERSONALITY NOS	30182	AVOIDANT PERSONALITY
30111	CHRONIC HYPOMANIC PERSON	30183	BORDERLINE PERSONALITY
30113	CYCLOTHYMIC DISORDER	30184	PASSIVE-AGGRESSIV PERSON
30120	SCHIZOID PERSONALITY NOS	30189	PERSONALITY DISORDER NEC
30121	INTROVERTED PERSONALITY	3019	PERSONALITY DISORDER NOS
30122	SCHIZOTYPAL PERSONALITY	3071	ANOREXIA NERVOSA
3013	EXPLOSIVE PERSONALITY	31231	PATHOLOGICAL GAMBLING
3014	COMPULSIVE PERSONALITY	31232	KLEPTOMANIA
30150	HISTRIONIC PERSON NOS	31234	INTERMITT EXPLOSIVE DIS
30151	CHR FACTITIOUS ILLNESS	31235	ISOLATED EXPLOSIVE DIS
30159	HISTRIONIC PERSON NEC	31239	IMPULSE CONTROL DIS NEC
3016	DEPENDENT PERSONALITY		

DRG 429,MDC 19M,ORGANIC DISTURBANCES & MENTAL RETARDATION

PRINCIPAL DIAGNOSIS

2900	SENILE DEMENTIA UNCOMP	2949	ORGANIC BRAIN SYND NOS
29010	PRESENILE DEMENTIA	29900	INFANTILE AUTISM-ACTIVE
29011	PRESENILE DELIRIUM	29901	INFANTILE AUTISM-RESID
29012	PRESENILE DELUSION	29910	DISINTEGR PSYCH-ACTIVE
29013	PRESENILE DEPRESSION	29911	DISINTEGR PSYCH-RESIDUAL
29020	SENILE DELUSION	3079	SPECIAL SYMPTOM NEC/NOS
29021	SENILE DEPRESSIVE	3100	FRONTAL LOBE SYNDROME
2903	SENILE DELIRIUM	3101	ORGANIC PERSONALITY SYND
29040	ARTERIOSCLER DEMENT NOS	3108	NONPSYCHOT BRAIN SYN NEC
29041	ARTERIOSCLER DELIRIUM	3109	NONPSYCHOT BRAIN SYN NOS
29042	ARTERIOSCLER DELUSION	316	PSYCHIC FACTOR W OTH DIS
29043	ARTERIOSCLER DEPRESSIVE	317	MILD MENTAL RETARDATION
2908	SENILE PSYCHOSIS NEC	3180	MOD MENTAL RETARDATION
2909	SENILE PSYCHOT COND NOS	3181	SEVERE MENTAL RETARDAT
29381	ORGANIC DELUSIONAL SYND	3182	PROFOUND MENTAL RETARDAT
29382	ORGANIC HALLUCINOSIS SYN	319	MENTAL RETARDATION NOS
29383	ORGANIC AFFECTIVE SYND	7580	DOWN'S SYNDROME
29389	TRANSIENT ORG MENTAL NEC	7581	PATAU'S SYNDROME
2940	AMNESTIC SYNDROME	7582	EDWARDS' SYNDROME
2941	DEMENTIA IN OTH DISEASES	797	SENILITY W/O PSYCHOSIS
2948	ORGANIC BRAIN SYND NEC		

DRG 430,MDC 19M,PSYCHOSES

PRINCIPAL DIAGNOSIS

29500	SIMPL SCHIZOPHREN-UNSPEC	29582	SCHIZOPHRENIA NEC-CHR
29501	SIMPL SCHIZOPHREN-SUBCHR	29583	SCHIZO NEC-SUBCHR/EXACER
29502	SIMPLE SCHIZOPHREN-CHR	29584	SCHIZO NEC-CHR/EXACERB
29503	SIMP SCHIZ-SUBCHR/EXACER	29585	SCHIZOPHRENIA NEC-REMISS
29504	SIMPL SCHIZO-CHR/EXACERB	29590	SCHIZOPHRENIA NOS-UNSPEC
29505	SIMPL SCHIZOPHREN-REMISS	29591	SCHIZOPHRENIA NOS-SUBCHR
29510	HEBEPHRENIA-UNSPEC	29592	SCHIZOPHRENIA NOS-CHR
29511	HEBEPHRENIA-SUBCHRONIC	29593	SCHIZO NOS-SUBCHR/EXACER
29512	HEBEPHRENIA-CHRONIC	29594	SCHIZO NOS-CHR/EXACERB
29513	HEBEPHREN-SUBCHR/EXACERB	29595	SCHIZOPHRENIA NOS-REMISS
29514	HEBEPHRENIA-CHR/EXACERB	29600	MANIC DISORDER-UNSPEC
29515	HEBEPHRENIA-REMISSION	29601	MANIC DISORDER-MILD
29520	CATATONIA-UNSPEC	29602	MANIC DISORDER-MOD
29521	CATATONIA-SUBCHRONIC	29603	MANIC DISORDER-SEVERE
29522	CATATONIA-CHRONIC	29604	MANIC DIS-SEVERE W PSYCH
29523	CATATONIA-SUBCHR/EXACERB	29605	MANIC DIS-PARTIAL REMISS
29524	CATATONIA-CHR/EXACERB	29606	MANIC DIS-FULL REMISSION
29525	CATATONIA-REMISSION	29610	RECUR MANIC DIS-UNSPEC
29530	PARANOID SCHIZO-UNSPEC	29611	RECUR MANIC DIS-MILD
29531	PARANOID SCHIZO-SUBCHR	29612	RECUR MANIC DIS-MOD
29532	PARANOID SCHIZO-CHRONIC	29613	RECUR MANIC DIS-SEVERE
29533	PARAN SCHIZO-SUBCHR/EXAC	29614	RECUR MANIC-SEV W PSYCHO
29534	PARAN SCHIZO-CHR/EXACERB	29615	RECUR MANIC-PART REMISS
29535	PARANOID SCHIZO-REMISS	29616	RECUR MANIC-FULL REMISS
29540	AC SCHIZOPHRENIA-UNSPEC	29620	DEPRESS PSYCHOSIS-UNSPEC
29541	AC SCHIZOPHRENIA-SUBCHR	29621	DEPRESS PSYCHOSIS-MILD
29542	AC SCHIZOPHRENIA-CHR	29622	DEPRESSIVE PSYCHOSIS-MOD
29543	AC SCHIZO-SUBCHR/EXACERB	29623	DEPRESS PSYCHOSIS-SEVERE
29544	AC SCHIZOPHR-CHR/EXACERB	29624	DEPR PSYCHOS-SEV W PSYCH
29545	AC SCHIZOPHRENIA-REMISS	29625	DEPR PSYCHOS-PART REMISS
29550	LATENT SCHIZOPHREN-UNSP	29626	DEPR PSYCHOS-FULL REMISS
29551	LAT SCHIZOPHREN-SUBCHR	29630	RECURR DEPR PSYCHOS-UNSP
29552	LATENT SCHIZOPHREN-CHR	29631	RECURR DEPR PSYCHOS-MILD
29553	LAT SCHIZO-SUBCHR/EXACER	29632	RECURR DEPR PSYCHOS-MOD
29554	LATENT SCHIZO-CHR/EXACER	29633	RECUR DEPR PSYCH-SEVERE
29555	LAT SCHIZOPHREN-REMISS	29634	REC DEPR PSYCH-PSYCHOTIC
29560	RESID SCHIZOPHREN-UNSP	29635	RECUR DEPR PSYC-PART REM
29561	RESID SCHIZOPHREN-SUBCHR	29636	RECUR DEPR PSYC-FULL REM
29562	RESIDUAL SCHIZOPHREN-CHR	29640	BIPOL AFF, MANIC-UNSPEC
29563	RESID SCHIZO-SUBCHR/EXAC	29641	BIPOLAR AFF, MANIC-MILD
29564	RESID SCHIZO-CHR/EXACERB	29642	BIPOLAR AFFEC, MANIC-MOD
29565	RESID SCHIZOPHREN-REMISS	29643	BIPOL AFF, MANIC-SEVERE
29570	SCHIZOAFFECTIVE-UNSPEC	29644	BIPOL MANIC-SEV W PSYCH
29571	SCHIZOAFFECTIVE-SUBCHR	29645	BIPOL AFF MANIC-PART REM
29572	SCHIZOAFFECTIVE-CHRONIC	29646	BIPOL AFF MANIC-FULL REM
29573	SCHIZOAFF-SUBCHR/EXACER	29650	BIPOLAR AFF, DEPR-UNSPEC
29574	SCHIZOAFFECT-CHR/EXACER	29651	BIPOLAR AFFEC, DEPR-MILD
29575	SCHIZOAFFECTIVE-REMISS	29652	BIPOLAR AFFEC, DEPR-MOD
29580	SCHIZOPHRENIA NEC-UNSPEC	29653	BIPOL AFF, DEPR-SEVERE
29581	SCHIZOPHRENIA NEC-SUBCHR	29654	BIPOL DEPR-SEV W PSYCH

29655	BIPOL AFF DEPR-PART REM	2970	PARANOID STATE, SIMPLE
29656	BIPOL AFF DEPR-FULL REM	2971	PARANOIA
29660	BIPOL AFF, MIXED-UNSPEC	2972	PARAPHRENIA
29661	BIPOLAR AFF, MIXED-MILD	2973	SHARED PARANOID DISORDER
29662	BIPOLAR AFFEC, MIXED-MOD	2978	PARANOID STATES NEC
29663	BIPOL AFF, MIXED-SEVERE	2979	PARANOID STATE NOS
29664	BIPOL MIXED-SEV W PSYCH	2980	REACT DEPRESS PSYCHOSIS
29665	BIPOL AFF, MIX-PART REM	2981	EXCITATIV TYPE PSYCHOSIS
29666	BIPOL AFF, MIX-FULL REM	2983	ACUTE PARANOID REACTION
2967	BIPOLAR AFFECTIVE NOS	2984	PSYCHOGEN PARANOID PSYCH
2960	MANIC-DEPRESSIVE NOS	2988	REACT PSYCHOSIS NEC/NOS
2961	ATYPICAL MANIC DISORDER	2989	PSYCHOSIS NOS
2962	ATYPICAL DEPRESSIVE DIS	29980	CHILD PSYCHOS NEC-ACTIVE
29689	MANIC-DEPRESSIVE NEC	29981	CHILD PSYCHOS NEC-RESID
29690	AFFECTIVE PSYCHOSIS NOS	29990	CHILD PSYCHOS NOS-ACTIVE
29699	AFFECTIVE PSYCHOSES NEC	29991	CHILD PSYCHOS NOS-RESID

DRG 431,MDC 19M,CHILDHOOD MENTAL DISORDERS

PRINCIPAL DIAGNOSIS

30752	PICA	31382	IDENTITY DISORDER
3076	ENURESIS	31383	ACADEMIC UNDERACHIEVMENT
3077	ENCOPRESIS	31389	EMOTIONAL DIS CHILD NEC
31200	UNSOCIAL AGGRESS-UNSPEC	3139	EMOTIONAL DIS CHILD NOS
31201	UNSOCIAL AGGRESSION-MILD	31400	ATTN DEFIC NONHYPERACT
31202	UNSOCIAL AGGRESSION-MOD	31401	ATTN DEFICIT W HYPERACT
31203	UNSOCIAL AGGRESS-SEVERE	3141	HYPERKINET W DEVEL DELAY
31210	UNSOCIAL UNAGGRESS-UNSP	3142	HYPERKINETIC CONDUCT DIS
31211	UNSOCIAL UNAGGRESS-MILD	3148	OTHER HYPERKINETIC SYND
31212	UNSOCIAL UNAGGRESS-MOD	3149	HYPERKINETIC SYND NOS
31213	UNSOCIAL UNAGGR-SEVERE	31500	READING DISORDER NOS
31220	SOCIAL CONDUCT DIS-UNSP	31501	ALEXIA
31221	SOCIAL CONDUCT DIS-MILD	31502	DEVELOPMENTAL DYSLEXIA
31222	SOCIAL CONDUCT DIS-MOD	31509	READING DISORDER NEC
31223	SOCIAL CONDUCT DIS-SEV	3151	ARITHMETICAL DISORDER
31230	IMPULSE CONTROL DIS NOS	3152	OTH LEARNING DIFFICULTY
31233	PYROMANIA	31531	DEVELOPMENT LANGUAGE DIS
3124	MIX DIS CONDUCT/EMOTION	31539	SPEECH/LANGUAGE DIS NEC
3128	OTHER CONDUCT DISTURB	3154	COORDINATION DISORDER
3129	CONDUCT DISTURBANCE NOS	3155	MIXED DEVELOPMENT DIS
31321	SHYNESS DISORDER-CHILD	3158	DEVELOPMENT DELAYS NEC
31322	INTROVERTED DIS-CHILD	3159	DEVELOPMENT DELAY NOS
31323	ELECTIVE MUTISM	78461	ALEXIA AND DYSLEXIA
3133	RELATIONSHIP PROBLEMS	78469	SYMBOLIC DYSFUNCTION NEC
31381	OPPOSITIONAL DISORDER		

DRG 432,MDC 19M,OTHER DIAGNOSES OF MENTAL DISORDERS

PRINCIPAL DIAGNOSIS

V7109	OBSERV-MENTAL COND NEC	30289	PSYCHOSEXUAL DIS NEC
2982	REACTIVE CONFUSION	3029	PSYCHOSEXUAL DIS NOS
3020	HOMOSEXUALITY	3068	PSYCHOGENIC DISORDER NEC
3021	ZOOPHILIA	3070	STAMMERING STUTTERING
3022	PEDOPHILIA	3073	STEREOTYPED MOVEMENTS
3023	TRANSVESTISM	30740	NONORGANIC SLEEP DIS NOS
3024	EXHIBITIONISM	30741	TRANSIENT INSOMNIA
30250	TRANS-SEXUALISM NOS	30742	PERSISTENT INSOMNIA
30251	TRANS-SEXUALISM, ASEXUAL	30743	TRANSIENT HYPERSOMNIA
30252	TRANS-SEXUAL, HOMOSEXUAL	30744	PERSISTENT HYPERSOMNIA
30253	TRANS-SEX, HETEROSEXUAL	30745	DISRUPT SLEEP-WAKE CYCLE
3026	PSYCHOSEX IDENTITY DIS	30746	SOMNAMBULISM/NGHT TERROR
30270	PSYCHOSEXUAL DYSFUNC NOS	30747	SLEEP STAGE DYSFUNC NEC
30271	INHIBITED SEXUAL DESIRE	30748	REPETIT SLEEP INTRUSION
30272	INHIBITED SEX EXCITEMENT	30749	NONORGANIC SLEEP DIS NEC
30273	INHIBITED FEMALE ORGASM	30750	EATING DISORDER NOS
30274	INHIBITED MALE ORGASM	30751	BULIMIA
30275	PREMATURE EJACULATION	30759	EATING DISORDER NEC
30276	FUNCTIONAL DYSPAREUNIA	78050	SLEEP DISTURBANCE NOS
30279	PSYCHOSEXUAL DYSFUNC NEC	78052	INSOMNIA NEC
30281	FETISHISM	78054	HYPERSOMNIA NEC
30282	VOYEURISM	78055	IRREG SLEEP-WAKE RHY NOS
30283	SEXUAL MASOCHISM	78056	SLEEP STAGE DYSFUNCTIONS
30284	SEXUAL SADISM	78059	SLEEP DISTURBANCES NEC
30285	GENDER IDENT DIS, ADULT	78460	SYMBOLIC DYSFUNCTION NOS

ATTACHMENT B

SUMMARY OF NEW JERSEY'S

PHYSICIAN REVIEW COMMITTEE MEETING

ON MDC 05 - MENTAL DISORDERS

NOTE: Mental Disorders - MDC 05 - became MDC 19 during construction of the 468 DRGs

State of New Jersey
DEPARTMENT OF HEALTH
JOHN FITCH PLAZA
P.O. BOX 1540, TRENTON, N.J. 08625

JOANNE E. FINLEY, M.D., M.P.H.
COMMISSIONER

MEMORANDUM

TO: MDC 05, Physician Review Committee

FROM: Leo K. Lichtig, Ph.D., Econometrician

SUBJECT: Summary of June 29, 1981 Meeting

DATE: July 6, 1981

Thank you for attending the June 29, 1981 meeting to review the new DRGs developed for MDC 05, Mental Disorders. The session was highly productive and the input you provided was invaluable. Attached is a draft summary of the meeting. Could you please review this draft and let me know by July 20, 1981 if you have any comments or corrections.

Once again, thank you for your assistance and I will let you know about Yale's response to our recommendations.

Leo K. Lichtig, Ph.D.
Econometrician
Health Economics Services
Case-Mix Project

LKL:vc

attachment

D R A F T

MDC 05

MENTAL DISORDERS

SUMMARY OF PHYSICIAN REVIEW SESSION

NEW JERSEY STATE DEPARTMENT OF HEALTH

TRENTON, NEW JERSEY

ATTENDEES:

Warren B. Nestler, M.D. (Internal Medicine) Overlook Hospital
Michael Alpert, M.D. (Psychiatry) St. Clare's Hospital
James Cowan, M.D. (Psychiatry) East Orange General Hospital
Robert K. Davies, M.D. (Psychiatry) Fair Oaks Hospital
Jamie Horn (Administration/Psychiatry) East Orange General Hospital
Jack B. Krenens, M.D. (Psychiatry) Monmouth Medical Center
Irwin N. Perr, M.D. (Psychiatry) Rutgers CMDNJ
Joanne E. Finley, M.D., M.P.H. (Pediatrics) NJSDOH
Joan Loughran, Medical Records, Medical Center of Princeton
Marcia Stachyra, R.N., Ph.D., Psychiatric Nursing, Rutgers College of Nursing
Leo K. Lichtig, Ph.D., NJSDOH
Faith K. Goldschmidt, NJSDOH
Larry L. Eitel, NJSDOH

The following represents the conclusions reached during the session:

1. Post concussion Syndrome (3102) would likely be a readmission after a trauma admission; the concussion would likely be the principal diagnosis for the first admission. For the readmission, the case is at least as likely to be psychiatric as neurological.

2. The following codes should be moved from Acute Episodes to Organic:

   29382 Organic Hallucinosis Syndrome

   29383 Organic Affective Syndrome

3. The following codes should be moved from Personality Disorders/Neuroses to Other:

   31500 Reading Disorder Nos

   31501 Alexia

   31502 Developmental Dyslexia

31509 Reading Disorder Nec

3151 Arithmetical Disorder

3152 Oth Learning Difficulty

31531 Development Language Dis

31539 Speech/Language Dis Nec

3154 Coordination Disorder

3155 Mixed Development Dis

3158 Development Delays Nec

3159 Development Delay Nos

4. The following codes should be moved from Psychoses to Other:

31400 Attn Defic Nonhyperact

31401 Attn Deficit W Hyperact

3141 Hyperkinet W Develop Delay

3142 Hyperkinetic Conduct Dis

3148 Other Hyperkinetic Synd

3149 Hyperkinetic Synd Nos

5. The Personality Disorders/Neuroses group should be split on age: 0-18 vs. 19 +. Adolesents will tend to stay longer, and this is supported by the data from Yale.

6. The following codes should be moved from Organic to Acute Episodes:

30741 Transient Insomnia

30743 Transient Hypersomnia

7. The following codes should be moved from Organic to Personality Disorders/ Neuroses:

3067 Psychogenic Sensory Dis

3069 Psychogenic Disorder Nos

30746 Somnambulism/Night Terror

3071 Anorexia Nervosa

30751 Bulimia

30754 Psychogenic Vomiting

30780 Psychogenic Pain Nos

30789 Psychogenic Pain Nec

8. The following codes should be moved from Organic to Other:

3073 Stereotyped Movements

30740 Nonorganic Sleep Dis Nos

30742 Persistent Insomnia

30744 Persistent Hypersomnia

30745 Disrupt Sleep-Wake Cycle

30747 Sleep Stage Dysfunc Nec

30748 Repetit Sleep Intrusion

30749 Nonorganic Sleep Dis Nec

30750 Eating Disorder Nos

30752 Pica

30753 Psychogenic Rumination

30759 Eating Disorder Nec

3077 Encopresis

3079 Special Symptom Nec/Nos

9. Enuresis (3076) should be in MDC 05 rather than MDC 13, Diseases and Disorders of the Kidney and Urinary Tract. It should then be placed in Other.

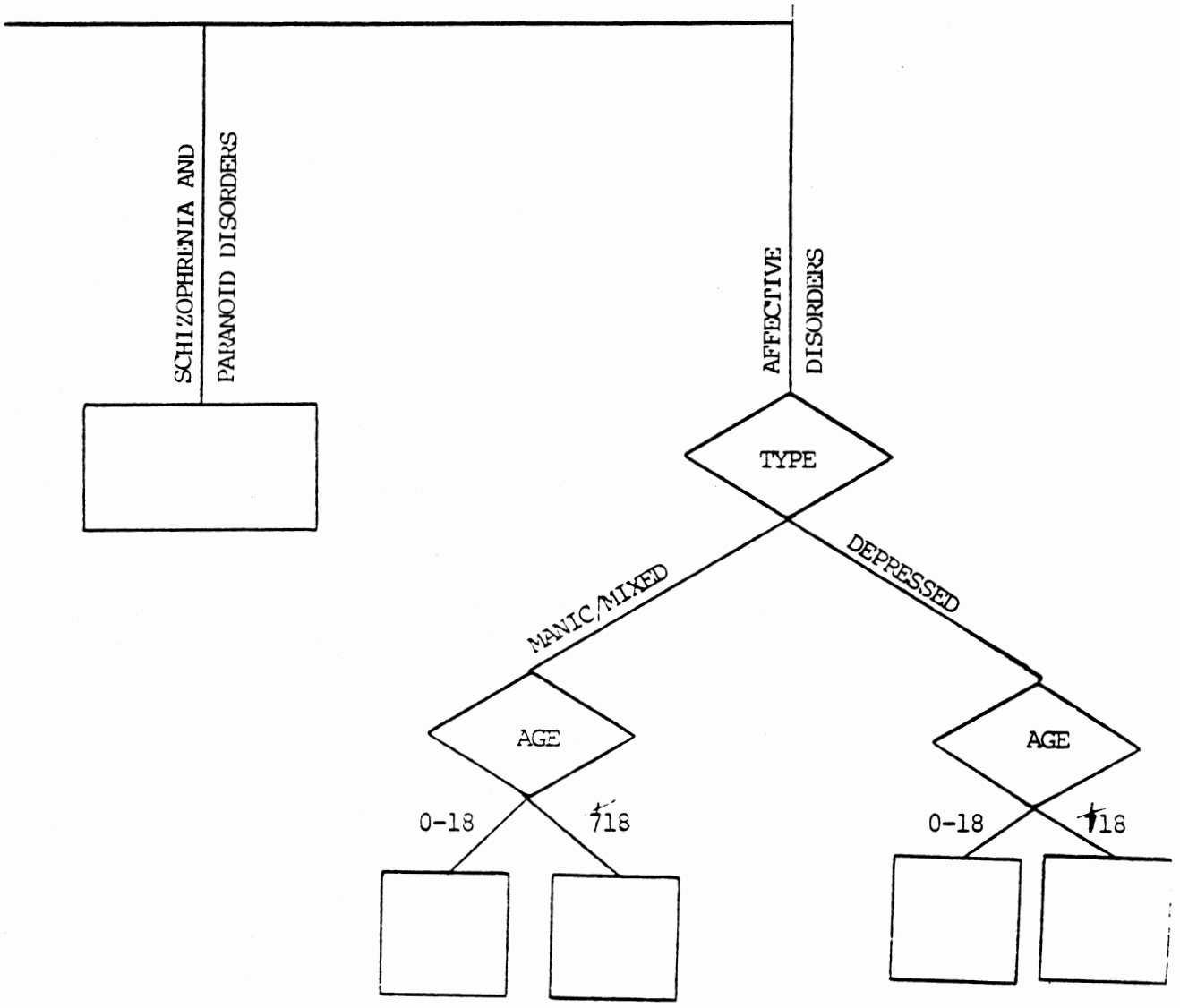
10. Code 2982, Reactive Confusion, should be moved from Psychoses to Other.

11a. All manic and bipolar diagnoses should be combined with the depression diagnoses to form a group called "Affective Disorders." The codes remaining in the Psychoses group should remain together with the title "Schizophrenia and Paranoid Disorders."

11b. The Affective Disorders group should then be split into "Manic/Mixed" and "Depressed" groups. Appendicies A, B and C list the diagnoses in these new groups.

11c. Both Affective Disorders groups should be split on age to separate adolescents:0-18, 18+.

11d. The modified section of the tree is as follows:



APPENDIX A

SCHIZOPHRENIA AND PARANOID DISORDERS

CODE	DESCRIPTION
29500	SIMPL SCHIZOPHREN.-UNSPEC
29501	SIMPL SCHIZOPHREN -SUBCHR
29502	SIMPLE SCHIZOPHREN-CHR
20503	SIMP SCHIZ-SUBCHR/EXACER
29504	SIMPL SCHIZO-CHR/EXACERB
29505	SIMPL SCHIZOPHREN-REMISS
29510	HEBEPHPENIA-UNSPEC
29511	HEBEPHRENIA-SUBCHRONIC
29512	HEBEPHRENIA-CHRONIC
29513	HEBEPHREN-SUBCHR/EXACERB
29514	HEBEPHRENIA-CHR/EXACERB
29515	HEBEPHRENIA-REMISSION
29520	CATATONIA-UNSPEC
29521	CATATONIA-SUBCHPONIC
29522	CATATONIA-CHRONIC
29523	CATATONIA-SUBCHR/EXACERB
29524	CATATONIA-CHR/EACERB
29525	CATATONIA-REMISSION
29530	PARANOID SCHIZO-UNSPEC
29531	PARANOID SCHIZO-SUBCHR
29532	PARANOID SCHIZO-CHRONIC
29533	PARAN SCHIZO-SUBCHR/EXAC
29534	PARAN SCHIZO-CHR/EXACERB
29535	PARANOID SCHIZO-REMISS
29540	AC SCHIZOPHRENIA-UNSPEC
29541	AC SCHIZOPHRENIA-SUBCHR
29542	AC SCHIZOPHRENIA-CHR
29543	AC SCHIZO-SUBCHR/EXACERB
29544	AC SCHIZOPHR-CHR/EXACERB
29545	AC SCHIZOPHRENIA-REMISS
29550	LATENT SCHIZOPHREN-UNSP
29551	LAT SCHIZOPHREN-SUBCHR
29552	LATENT SCHIZOPHREN-CHR
29553	LAT SCHIZO-SUBCHR/EXACER
29554	LATENT SCHIZO-CHR/EXACER
29555	LAT SCHIZOPHREN-REMISS
29560	RESID SCHIZOPHREN-UNSP
29561	RESID SCHIZOPHREN-SUBCHR
29562	RESIDUAL SCHIZOPHREN-CHR
29563	RESID SCHIZO-SUBCHR/EXAC
29564	RESID SCHIZO-CHR/EACERB
29565	RESID SCHIZOPHREN-REMISS
29570	SCHIZOAFFECTIVE-UNSPEC
29571	SCHIZOAFFECTIVE-SUBCHR
29572	SCHIZOAFFECTIVE-CHPONIC
29573	SCHIZOAFF-SUBCHR/EXACER
29574	SCHIZOAFFECT-CHR/EXACER
29575	SCHIZOAFFECTIVE-REMISS
29580	SCHIZOPHRENIA NEC-UNSPEC
29581	SCHIZOPHRENIA NEC-SUBCHR
29582	SCHIZOPHRENIA NEC-CHR
29583	SCHIZO NEC-SUBCHR/EXACER
29584	SCHIZO NEC-CHR/EXACERB
29585	SCHIZOPHRENIA NEC-REMIS
29590	SCHIZOPHRENIA NOS-UNSPEC
29591	SCHIZOPHRENIA NOS-SUBCH
29592	SCHIZOPHRENIA NOS-CHR
29593	SCHIZO NOX-SUBCHR/EXACE
29594	SCHIZO NOS-CHR/EXACERB
29595	SCHIZOPHRENIA NOS-REMIS
2970	PARANDID STATE, SIMPLE
2971	PARANOIA
2972	PARAPHRRNIA
2973	SHARED PARANOID DISORDER
2978	PARANOID STATES NEC
2979	PARANOID STATE NOS
2981	EXCITATIV TYPE PSYCHOSI
2983	ACUTE PARANOID REACTION
2984	PSYCHOGEN PARANOID PSYCH
2988	REACT PSYCHOSIS NEC/NOS
2989	PSYCHOSIS NOS

APPENDIX B

AFFECTIVE DISORDERS:

MANIC/MIXED

CODE	DESCRIPTION
29600	MANIC DISORDER-UNSPEC
29601	MANIC DISORDER-MILD
29602	MANIC DISORDER-MOD
29603	MANIC DISORDER-SEVERE
29604	MANIC DIS-SEVERE W PSYCH
29605	MANIC DIS-PARTIAL REMIS
29606	MANIC DIS-FULL REMISSION
29610	RECUR MANIC DIS-UNSPEC
29611	RECUR MANIC DIS-MILD
29612	RECUR MANIC DIS-MOD
29613	RECUR MANIC DIS-SEVERE
29614	RECUR MANIC-SEV W PSYCH
29615	RECUR MANIC-PART REMISS
29616	RECUR MANIC-FULL REMISS
29640	BIPOL AFF, MANIC-UNSPEC
29641	BIPOLAR AFF, MANIC-MILD
29642	BIPOLAR AFF, MANIC-MOD
29643	BIPOL AFF, MANIC-SEVERE
29644	BIPOL MANIC-SEV W PSYCH
29645	BIPOL AFF MANIC-PART RE
29646	BIPOL AFF MANIC-FULL RE
29660	BIPOL AFF, MIXED-UNSPEC
29661	BIPOLAR AFF, MIXED-MILD
29662	BIPOLAR AFFEC, MIXED-MOD
29663	BIPOL AFF, MIXED-SEVERE
29664	BIPOL MIXED-SEV W PSYCH
29665	BIPOL AFF, MIX-PART REM
29666	BIPOL AFF, MIX-FULL REM
2967	BIPOLAR AFFECTIVE NOS
29680	MANIC-DEPRESSIVE NOS
29681	ATYPICAL MANIC DISORDER
29689	MANIC-DEPRESSIVE NEC
29690	AFFECTIVE PSYCHOSIS NOS
29699	AFFECTIVE PSYCHOSIS NEC

APPENDIX C

AFFECTIVE DISORDERS:

DEPRESSED

CODE	DESCRIPTION
29620	DEPRESS PSYCHOSIS-UNSPEC
29621	DEPRESS PSYCHOSIS-MILD
29622	DEPRESSIVE PSYCHOSIS-MOD
29623	DEPRESS PSYCHOSIS-SEVERE
29624	DEPR PSYCHOS-SEV W PSYCH
29625	DEPR PSYCHOS-PART REMISS
29626	DEPR PSYCHOS-FULL REMISS
29630	RECUR DEPR PSYCHOS-UNSP
29631	RECURR DEPRE PSYCHOS-MILD
29632	RECURR DEPR PSYCHOS-MOD
39633	RECUR DEPR PSYCH-SEVERE
29634	REC DEPR PSYCH-PSYCHOTIC
29635	RECUR DEPR PSYC-PART REM
29636	RECUR DEPR PSYC-FULL REM
29650	BIPOLAR AFF, DEPR-UNSPEC
29651	BIPOLAR AFFEC, DEPR-MILD
29652	BIPOLAR AFFEC, DEPR-MOD
29653	BIPOL AFF, DEPR-SEVERE
29654	BIPOL DEPR-SEV W PSYCH
29655	BIPOL AFF DEPR-PART REM
29656	BIPOL AFF DEPR-FULL REM
29682	ATYPICAL DEPRESSIVE DIS
2980	REACT DEPRESS PSYCHOSIS
2004	NEUROTIC DEPRESSION
30112	CHR DEPRESSIVE PERSON
3091	PROLONG DEPRESSIVE REACT
311	DEPRESSIVE DISORDER NEC

ATTACHMENT C

HISTOGRAMS OF

1979 NEW JERSEY

STATE-WIDE DATA

NOTE: Trim Points for 468 DRGs were set on these histograms.
VALUE is the number of days.
OPS is the number of patients discharged on each day listed.
PCT is the percent of total patients in that DRG discharged on each day.
CUM% is the cumulative percent of total patients discharged up to each day.
The MEAN is average length of stay using different statistical measures.
SD is distribution of length of stay around each average length of stay.
LO TRIM and HI TRIM are trim points set with statistical computer programs.

DRG 121, LOC I P, MENTAL DISORDERS, W ANY OP PROC

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	313	24.195	26.284		
DIST EST	196	15.189	6.562		
STD TRIM	261	14.732	9.342	0	35
LOGN TRIM	230	18.848	9.827	5	49

P(<5)=.0066 (2.1 OBS)
P(>49)=.0010 (.3 OBS)

INTERVAL POINTS: 4 , 29

VALUE	OBS	PCT	CUM %	
.00	10	3.19	3.19	******
1.00	11	3.51	6.71	*******
2.00	12	3.83	10.54	*******
3.00	5	1.60	12.14	***
4.00	6	1.92	14.06	***
5.00	7	2.24	16.29	****
6.00	8	2.56	18.85	*****
7.00	7	2.24	21.09	****
8.00	9	2.88	23.96	*****
9.00	10	3.19	27.16	******
10.00	9	2.88	30.03	*****
11.00	8	2.56	32.59	*****
12.00	13	4.15	36.74	********
13.00	9	2.88	39.62	*****
14.00	12	3.83	43.45	*******
15.00	6	1.92	45.37	***
16.00	14	4.47	49.84	********
17.00	7	2.24	52.08	****
18.00	10	3.19	55.27	******
19.00	4	1.28	56.55	**
20.00	14	4.47	61.02	********
21.00	5	1.60	62.62	***
22.00	5	1.60	64.22	***
23.00	6	1.92	66.13	***
24.00	9	2.88	69.01	*****
25.00	5	1.60	70.61	***
26.00	3	.96	71.57	*
27.00	6	1.92	73.48	***
28.00	4	1.28	74.76	**
29.00	6	1.92	76.68	***
30.00	9	2.88	79.55	*****
31.00	3	.96	80.51	*
32.00	1	.32	80.83	
33.00	2	.64	81.47	*
34.00	2	.64	82.11	*
35.00	4	1.28	83.39	**
36.00	1	.32	83.71	
37.00	1	.32	84.03	
-				
41.00	2	.64	84.66	*
42.00	2	.64	85.30	*
43.00	1	.32	85.62	
44.00	2	.64	86.26	*
-				
49.00	2	.64	86.90	*

64x

49.00	2	.64	87.54	*
50.00	2	.64	88.19	*
51.00	0	.00	88.19	
52.00	1	.32	88.50	
53.00	1	.32	88.82	
54.00	2	.64	89.46	*
55.00	1	.32	89.78	
56.00	0	.00	89.78	
57.00	2	.64	90.42	*
58.00	1	.32	90.73	
59.00	1	.32	91.05	
60.00	0	.00	91.05	
61.00	1	.32	91.37	
-				
64.00	6	1.92	93.29	***
65.00	1	.32	93.61	
66.00	1	.32	93.93	
-				
69.00	1	.32	94.25	
70.00	2	.64	94.89	*
71.00	1	.32	95.21	
72.00	1	.32	95.53	
73.00	1	.32	95.84	
-				
91.00	1	.32	96.17	
92.00	1	.32	96.49	
-				
101.00	1	.32	96.81	
-				
105.00	1	.32	97.12	
106.00	0	.00	97.12	
107.00	1	.32	97.44	
-				
111.00	1	.32	97.75	
112.00	1	.32	98.07	
-				
119.00	1	.32	98.40	
-				
124.00	1	.32	98.72	
-				
134.00	1	.32	99.04	
-				
143.00	1	.32	99.36	
-				
161.00	1	.32	99.68	
-				
164.00	1	.32	100.00	
-				

65x

DRG 425,MDC 19H,ACUTE ADJUST4ENT REACT & DISTURB OF PSYCHOSOCIAL DYSFUNCT

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	1572	7.218	8.388		
DIST EST	1095	4.868	2.284		
STD TRIM	1338	4.759	2.975	0	12
LOGN TRIM	1258	6.293	3.725	2	17

P(<2)=.0383 (60.2OBS)
P(>17)=.0008 (1.3 OBS)

INTERVAL POINTS: 1 , 10

VALUE	OBS	PCT	CUM %	
.00	53	3.37	3.37	******
1.00	142	8.97	12.34	*****************
2.00	145	9.22	21.56	******************
3.00	177	11.26	32.82	**********************
4.00	177	11.26	44.08	**********************
5.00	168	10.69	54.77	*********************
6.00	115	7.32	62.09	**************
7.00	107	6.81	68.89	*************
8.00	82	5.22	74.11	**********
9.00	59	3.75	77.86	*******
10.00	49	3.12	80.98	******
11.00	38	2.42	83.40	****
12.00	27	1.72	85.11	***
13.00	28	1.78	86.90	***
14.00	23	1.46	88.36	**
15.00	24	1.53	89.89	***
16.00	20	1.27	91.16	**
17.00	19	1.21	92.37	**
18.00	10	.64	93.00	*
19.00	13	.83	93.83	*
20.00	14	.89	94.72	*
21.00	13	.83	95.55	*
22.00	10	.64	96.18	*
23.00	2	.13	96.31	
24.00	9	.57	96.88	*
25.00	7	.45	97.33	
26.00	8	.51	97.84	*
27.00	5	.32	98.16	
28.00	3	.19	98.35	
29.00	0	.00	98.35	
30.00	4	.25	98.60	
31.00	1	.06	98.66	
32.00	2	.13	98.79	
33.00	1	.06	98.85	
34.00	3	.19	99.05	
35.00	2	.13	99.17	
36.00	1	.06	99.24	
37.00	2	.13	99.36	
-				
40.00	1	.06	99.43	
41.00	1	.06	99.49	
-				
50.00	1	.06	99.55	
51.00	0	.00	99.55	
52.00	1	.06	99.62	

66x

61.00	1	.06	99.68
62.00	1	.06	99.75
65.00	1	.06	99.81
73.00	1	.06	99.87
80.00	1	.06	99.94
171.00	1	.06	100.00

DRG 425,MDC 19,NEUROSES,W DEPRESSIVE NEUROSIS PDX

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	4732	10.876	10.043		
DIST EST	3523	8.661	5.157		
STD TRIM	4398	9.959	6.315	0	25
LOGN TRIM	4217	11.189	7.723	2	39

P(<2)=.0085 (40.4OBS)
P(>39)=.0011 (5.4 OBS)

INTERVAL POINTS: 1 , 21

VALUE	OBS	PCT	CUM %	
.00	168	3.55	3.55	*******
1.00	275	5.81	9.36	**********
2.00	280	5.92	15.28	**********
3.00	275	5.81	21.09	**********
4.00	289	6.11	27.20	**********
5.00	234	4.94	32.20	**********
6.00	268	5.66	37.86	**********
7.00	297	6.28	45.14	**********
8.00	256	5.41	50.55	**********
9.00	226	4.78	55.33	**********
10.00	212	4.48	59.81	********
11.00	203	4.29	64.10	********
12.00	165	3.49	67.58	******
13.00	153	3.23	70.82	******
14.00	153	3.23	74.05	******
15.00	131	2.77	76.82	*****
16.00	109	2.30	79.12	****
17.00	99	2.09	81.21	****
18.00	103	2.18	83.39	****
19.00	82	1.73	85.12	***
20.00	84	1.78	86.90	***
21.00	85	1.80	88.70	***
22.00	67	1.42	90.11	**
23.00	55	1.16	91.27	**
24.00	49	1.04	92.31	**
25.00	30	.63	92.94	*
26.00	31	.66	93.60	*
27.00	26	.55	94.15	*
28.00	35	.74	94.89	*
29.00	28	.59	95.48	*
30.00	20	.42	95.90	
31.00	20	.42	96.32	
32.00	19	.40	96.72	
33.00	18	.38	97.10	
34.00	16	.34	97.44	
35.00	13	.27	97.72	
36.00	16	.34	98.06	
37.00	5	.11	98.16	
38.00	9	.19	98.35	
39.00	6	.13	98.48	
40.00	7	.15	98.63	
41.00	4	.08	98.71	
42.00	1	.02	98.73	
43.00	6	.13	98.86	
44.00	2	.04	98.90	

68x

45.00	6	.13	99.03
46.00	3	.06	99.09
47.00	1	.02	99.11
48.00	5	.11	99.22
49.00	3	.06	99.28
50.00	0	.00	99.28
51.00	3	.06	99.34
52.00	2	.04	99.39
53.00	3	.06	99.45
54.00	2	.04	99.49
55.00	0	.00	99.49
56.00	4	.08	99.58
57.00	2	.04	99.62
58.00	1	.02	99.64
59.00	1	.02	99.66
60.00	1	.02	99.68
61.00	0	.00	99.68
62.00	1	.02	99.70
63.00	0	.00	99.70
64.00	3	.06	99.77
65.00	1	.02	99.79
66.00	1	.02	99.81
- 73.00	2	.04	99.85
- 76.00	1	.02	99.87
- 82.00	1	.02	99.89
- 87.00	1	.02	99.91
- 91.00	1	.02	99.94
- 98.00	1	.02	99.96
- 160.00	1	.02	99.98
- 165.00	1	.02	100.00
-			

DRG 427,MDC 19,NEUROSES,NO DEPRESSIVE NEUROSES PDX

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	718	8.198	8.517		
DIST EST	577	6.040	3.449		
STD TRIM	674	6.151	4.305	0	17
LOGN TRIM	638	8.044	5.480	2	26

P(<2)=.0348 (26.00BS)
P(>26)=.0010 (.8 OBS)

INTERVAL POINTS: 1 , 14

VALUE	OBS	PCT	CUM %	
.00	29	3.88	3.88	*******
1.00	56	7.49	11.36	**************
2.00	67	8.96	20.32	*****************
3.00	70	9.36	29.68	*****************
4.00	58	7.75	37.43	**************
5.00	70	9.36	46.79	*****************
6.00	61	8.15	54.95	***************
7.00	52	6.95	61.90	************
8.00	27	3.61	65.51	*******
9.00	38	5.08	70.59	**********
10.00	20	2.67	73.26	*****
11.00	32	4.28	77.54	********
12.00	22	2.94	80.48	*****
13.00	21	2.81	83.29	*****
14.00	13	1.74	85.03	***
15.00	15	2.01	87.03	****
16.00	11	1.47	88.50	**
17.00	12	1.60	90.11	***
18.00	9	1.20	91.31	**
19.00	8	1.07	92.38	**
20.00	4	.53	92.91	*
21.00	8	1.07	93.98	**
22.00	4	.53	94.52	*
23.00	3	.40	94.92	
24.00	6	.80	95.72	*
25.00	3	.40	96.12	
26.00	4	.53	96.66	*
27.00	1	.13	96.79	
28.00	3	.40	97.19	
29.00	5	.67	97.86	*
30.00	0	.00	97.86	
31.00	1	.13	97.99	
32.00	1	.13	98.13	
33.00	3	.40	98.53	
34.00	4	.53	99.06	*
-				
38.00	1	.13	99.20	
39.00	1	.13	99.33	
-				
44.00	1	.13	99.46	
45.00	2	.27	99.73	
-				
99.00	1	.13	99.87	
-				
120.00	1	.13	100.00	

DPG 428,DOC 1PV,DISORDERS OF PERSONALITY & IMPULSE CONTROL

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	467	10.820	10.229		
DIST EST	330	8.542	5.045		
STD TRIM	438	8.884	6.139	0	24
LOGN TRIM	418	10.467	7.193	2	38

P(<2)=.0086 (4.0 OBS)
P(>38)=.0011 (.5 OBS)

INTERVAL POINTS: 1 , 20

VALUE	OBS	PCT	CUM %	
.00	12	2.57	2.57	*****
1.00	24	5.14	7.71	**********
2.00	38	8.14	15.85	****************
3.00	32	6.85	22.70	**************
4.00	22	4.71	27.41	*********
5.00	30	6.42	33.83	************
6.00	27	5.78	39.61	***********
7.00	27	5.78	45.40	***********
8.00	21	4.50	49.89	*********
9.00	29	6.21	56.10	************
10.00	25	5.35	61.45	**********
11.00	14	3.00	64.45	******
12.00	15	3.21	67.67	******
13.00	16	3.43	71.09	******
14.00	19	4.07	75.16	********
15.00	8	1.71	76.87	***
16.00	16	3.43	80.30	******
17.00	12	2.57	82.87	*****
18.00	11	2.35	85.22	****
19.00	7	1.50	86.72	**
20.00	10	2.14	88.86	****
21.00	8	1.71	90.58	***
22.00	7	1.50	92.08	**
23.00	6	1.28	93.36	**
24.00	2	.43	93.79	
25.00	0	.00	93.79	
26.00	3	.64	94.43	*
27.00	0	.00	94.43	
28.00	2	.43	94.86	
-				
31.00	2	.43	95.29	
32.00	2	.43	95.72	
33.00	0	.00	95.72	
34.00	2	.43	96.15	
35.00	1	.21	96.36	
36.00	3	.64	97.00	*
37.00	1	.21	97.22	
38.00	0	.00	97.22	
39.00	1	.21	97.43	
-				
42.00	4	.86	98.29	*
43.00	0	.00	98.29	
44.00	2	.43	98.71	
45.00	0	.00	98.71	
46.00	2	.43	99.14	

47.00 –	1	.21	[illegible]
57.00 –	1	.21	[illegible]
64.00 –	1	.21	[illegible]
99.00 –	1	.21	100.00

DRG 424,MDC 19M,ORGANIC DISTURBANCES & MENTAL RETARDATION

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	1555	20.544	32.581		
DIST EST	1975	11.710	5.751		
STD TRIM	1317	11.436	7.269	0	29
LOGN TRIM	1311	14.305	9.291	3	43

P(<3)=.0035 (5.4 OBS)
P(>43)=.0010 (1.6 OBS)

INTERVAL POINTS: 3 , 25

VALUE	OBS	PCT	CUM %	
.00	16	1.03	1.03	**
1.00	43	2.77	3.79	*****
2.00	54	3.47	7.27	******
3.00	66	4.24	11.51	********
4.00	60	3.86	15.37	*******
5.00	81	5.21	20.58	**********
6.00	78	5.02	25.59	**********
7.00	84	5.40	31.00	**********
8.00	67	4.31	35.31	********
9.00	67	4.31	39.61	********
10.00	68	4.05	43.67	********
11.00	71	4.57	48.23	*********
12.00	55	3.54	51.77	*******
13.00	52	3.34	55.11	******
14.00	59	3.79	58.91	*******
15.00	42	2.70	61.61	*****
16.00	38	2.44	64.05	****
17.00	24	1.54	65.59	***
18.00	39	2.51	68.10	****
19.00	30	1.93	70.03	***
20.00	25	1.61	71.64	***
21.00	33	2.12	73.76	****
22.00	37	2.38	76.14	****
23.00	33	2.12	78.26	****
24.00	16	1.03	79.29	**
25.00	29	1.86	81.15	***
26.00	10	.64	81.80	*
27.00	24	1.54	83.34	***
28.00	11	.71	84.05	*
29.00	10	.64	84.69	*
30.00	9	.58	85.27	*
31.00	7	.45	85.72	
32.00	14	.90	86.62	*
33.00	11	.71	87.33	*
34.00	6	.39	87.72	
35.00	4	.26	87.97	
36.00	5	.32	88.30	
37.00	10	.64	88.94	*
38.00	12	.77	89.71	*
39.00	3	.19	89.90	
40.00	7	.45	90.35	
41.00	6	.39	90.74	
42.00	6	.39	91.13	
43.00	7	.45	91.58	
44.00	4	.26	91.83	

45.00	7	.45	92.28
46.00	7	.45	92.73
47.00	2	.13	92.86
48.00	4	.26	93.12
49.00	3	.19	93.31
50.00	4	.26	93.57
51.00	1	.06	93.63
52.00	4	.26	93.89
53.00	5	.32	94.21
54.00	2	.13	94.34
55.00	1	.06	94.40
56.00	0	.00	94.40
57.00	2	.13	94.53
58.00	0	.00	94.53
59.00	2	.13	94.66
60.00	0	.00	94.66
61.00	1	.06	94.73
62.00	1	.06	94.79
63.00	2	.13	94.92
64.00	0	.00	94.92
65.00	2	.13	95.05
66.00	2	.13	95.18
67.00	0	.00	95.18
68.00	2	.13	95.31
69.00	1	.06	95.37
70.00	0	.00	95.37
71.00	2	.13	95.50
72.00	1	.06	95.56
73.00	2	.13	95.69
74.00	0	.00	95.69
75.00	2	.13	95.82
76.00	1	.06	95.88
77.00	2	.13	96.01
78.00	0	.00	96.01
79.00	1	.06	96.08
80.00	1	.06	96.14
81.00	1	.06	96.21
82.00	1	.06	96.27
83.00	1	.06	96.33
84.00	1	.06	96.40
85.00	3	.19	96.59
-			
88.00	3	.19	96.78
89.00	0	.00	96.78
90.00	2	.13	96.91
91.00	0	.00	96.91
92.00	2	.13	97.04
93.00	2	.13	97.17
94.00	0	.00	97.17
95.00	1	.06	97.23
96.00	0	.00	97.23
97.00	1	.06	97.30
98.00	1	.06	97.36
99.00	0	.00	97.36
100.00	1	.06	97.43
101.00	2	.13	97.56
-			
105.00	2	.13	97.69
-			
110.00	1	.06	97.75
111.00	1	.06	97.81

111.00	1	.03	97.81
112.00	1	.06	97.88
-			
116.00	1	.06	97.94
-			
120.00	1	.06	98.01
121.00	0	.00	98.01
122.00	2	.13	98.13
123.00	1	.06	98.20
124.00	1	.06	98.26
-			
127.00	1	.06	98.33
128.00	1	.06	98.39
-			
131.00	1	.06	98.46
132.00	0	.00	98.46
133.00	2	.13	98.58
-			
139.00	1	.06	98.65
-			
147.00	1	.06	98.71
-			
161.00	1	.06	98.78
-			
168.00	1	.06	98.84
169.00	2	.13	98.97
-			
187.00	1	.06	99.03
188.00	0	.00	99.03
189.00	1	.06	99.10
-			
218.00	1	.06	99.16
-			
221.00	1	.06	99.23
-			
225.00	1	.06	99.29
-			
249.00	1	.06	99.36
-			
267.00	1	.06	99.42
-			
272.00	1	.06	99.48
-			
278.00	1	.06	99.55
-			
399.00	7	.45	100.00

DIG 430,MDC 19%,PSYCHOSES

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	9163	14.365	11.842		
DIST EST	7567	11.968	6.731		
STD TRIM	8590	12.285	8.157	0	33
LOGN TRIM	8079	15.179	9.590	3	51

P(<3)=.0087 (79.90BS)
P(>51)=.0011 (10.00BS)

INTERVAL POINTS: 1 , 27

VALUE	OBS	PCT	CUM %	
.00	254	2.77	2.77	*****
1.00	351	3.83	6.60	*******
2.00	360	3.93	10.53	*******
3.00	342	3.73	14.26	*******
4.00	389	4.24	18.50	********
5.00	400	4.37	22.87	********
6.00	390	4.26	27.13	********
7.00	443	4.83	31.96	*********
8.00	397	4.33	36.29	********
9.00	366	3.99	40.28	*******
10.00	402	4.39	44.67	********
11.00	402	4.39	49.06	********
12.00	356	3.89	52.95	*******
13.00	324	3.54	56.49	*******
14.00	340	3.71	60.20	*******
15.00	282	3.08	63.28	******
16.00	267	2.91	66.19	*****
17.00	263	2.87	69.06	*****
18.00	260	2.84	71.90	*****
19.00	245	2.67	74.57	*****
20.00	254	2.77	77.35	*****
21.00	252	2.75	80.10	*****
22.00	183	2.00	82.10	***
23.00	136	1.48	83.58	**
24.00	132	1.44	85.02	**
25.00	129	1.41	86.43	**
26.00	124	1.35	87.78	**
27.00	114	1.24	89.02	**
28.00	107	1.17	90.19	**
29.00	79	.86	91.05	*
30.00	68	.74	91.79	*
31.00	78	.85	92.64	*
32.00	76	.83	93.47	*
33.00	45	.49	93.96	
34.00	41	.45	94.41	
35.00	60	.65	95.06	*
36.00	37	.40	95.46	
37.00	38	.41	95.87	
38.00	37	.40	96.27	
39.00	35	.38	96.65	
40.00	26	.28	96.94	
41.00	25	.27	97.21	
42.00	20	.22	97.43	
43.00	29	.32	97.74	
44.00	15	.16	97.91	

45.00	11	.12	97.93
46.00	17	.19	98.01
47.00	10	.11	98.12
48.00	15	.16	98.29
49.00	14	.15	98.44
50.00	17	.19	98.62
51.00	7	.08	98.70
52.00	4	.04	98.74
53.00	9	.10	98.84
54.00	14	.15	99.00
55.00	6	.07	99.06
56.00	10	.11	99.17
57.00	7	.08	99.25
58.00	5	.05	99.30
59.00	1	.01	99.31
60.00	8	.09	99.40
61.00	7	.08	99.48
62.00	2	.02	99.50
63.00	2	.02	99.52
64.00	1	.01	99.53
65.00	4	.04	99.57
66.00	2	.02	99.60
67.00	0	.00	99.60
68.00	1	.01	99.61
69.00	3	.03	99.64
70.00	3	.03	99.67
71.00	1	.01	99.68
72.00	1	.01	99.69
73.00	2	.02	99.72
74.00	2	.02	99.74
75.00	4	.04	99.78
76.00	1	.01	99.79
77.00	2	.02	99.81
-			
80.00	1	.01	99.82
81.00	0	.00	99.82
82.00	1	.01	99.84
83.00	1	.01	99.85
-			
86.00	2	.02	99.87
87.00	1	.01	99.88
88.00	0	.00	99.88
89.00	1	.01	99.89
90.00	0	.00	99.89
91.00	1	.01	99.90
-			
99.00	1	.01	99.91
100.00	1	.01	99.92
101.00	0	.00	99.92
102.00	1	.01	99.93
-			
118.00	1	.01	99.94
-			
121.00	1	.01	99.95
122.00	0	.00	99.96
123.00	1	.01	99.97
-			
133.00	1	.01	99.98
-			
141.00	1	.01	99.99
-			

155.00 1 .01 100.00

DRG 431,MDC 17M,CHILDHOOD DISEASES

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	167	7.335	7.942		
DIST EST	122	4.811	3.269		
STD TRIM	146	4.918	4.103	0	15
LOGN TRIM	149	7.013	6.106	1	26

P(<1)=.0125 (2.1 OBS)
P(>26)=.0009 (.2 OBS)

INTERVAL POINTS: 1 , 12

VALUE	OBS	PCT	CUM %	
.00	13	7.78	7.78	**********
1.00	18	10.78	18.56	**********
2.00	27	16.17	34.73	**********
3.00	13	7.78	42.51	**********
4.00	9	5.39	47.90	*******
5.00	12	7.19	55.09	**********
6.00	10	5.99	61.08	********
7.00	11	6.59	67.66	**********
8.00	2	1.20	68.86	**
9.00	5	2.99	71.86	*****
10.00	6	3.59	75.45	******
11.00	8	4.79	80.24	********
12.00	3	1.80	82.04	***
13.00	1	.60	82.63	*
14.00	4	2.40	85.03	****
15.00	4	2.40	87.43	****
16.00	4	2.40	89.82	****
17.00	1	.60	90.42	*
18.00	1	.60	91.02	*
19.00	0	.00	91.02	
20.00	2	1.20	92.22	**
21.00	1	.60	92.81	*
22.00	1	.60	93.41	*
23.00	3	1.80	95.21	***
24.00	0	.00	95.21	
25.00	2	1.20	96.41	**
26.00	1	.60	97.01	*
-				
31.00	1	.60	97.60	*
32.00	1	.60	98.20	*
33.00	1	.60	98.80	*
-				
40.00	1	.60	99.40	*
-				
44.00	1	.60	100.00	*
-				

179

DRG 422,MDC 19,OTHER DIAGNOSES MENTAL

	OBS	MEAN	S.D.	LO TRIM	HI TRIM
UNTRIMMED	167	10.671	9.254		
DIST EST	137	8.737	5.560		
STD TRIM	157	9.076	6.632	0	26
LOGN TRIM	150	11.147	8.323	2	43

P(<2)=.0126 (2.1 OBS)
P(>43)=.0011 (.2 OBS)

INTERVAL POINTS: 1 , 21

VALUE	OBS	PCT	CUM %	
.00	8	4.79	4.79	*********
1.00	8	4.79	9.58	*********
2.00	12	7.19	16.77	**************
3.00	10	5.99	22.75	**********
4.00	15	8.98	31.74	**********
5.00	9	5.39	37.13	**********
6.00	4	2.40	39.52	****
7.00	7	4.19	43.71	********
8.00	14	8.38	52.10	**********
9.00	7	4.19	56.29	********
10.00	5	2.99	59.28	*****
11.00	4	2.40	61.68	****
12.00	7	4.19	65.87	********
13.00	3	1.80	67.66	***
14.00	5	2.99	70.66	*****
15.00	10	5.99	76.65	**********
16.00	3	1.80	78.44	***
17.00	3	1.80	80.24	***
18.00	3	1.80	82.04	***
19.00	7	4.19	86.23	********
20.00	2	1.20	87.43	**
21.00	5	2.99	90.42	*****
22.00	1	.60	91.02	*
23.00	1	.60	91.62	*
24.00	3	1.80	93.41	***
25.00	1	.60	94.01	*
-				
28.00	2	1.20	95.21	**
29.00	1	.60	95.81	*
30.00	0	.00	95.81	
31.00	1	.60	96.41	*
32.00	1	.60	97.01	*
-				
35.00	1	.60	97.60	*
36.00	0	.00	97.60	
37.00	1	.60	98.20	*
-				
40.00	2	1.20	99.40	**
-				
57.00	1	.60	100.00	*
-				

ATTACHMENT D

THE DRG SYSTEM IN NEW JERSEY

NOTE: A brief overview of New Jersey's System

The Diagnosis Related Group (DRG) System

in New Jersey

For additional information contact:

Faith K. Goldschmidt, Dir. Designate
Systems Analysis, Development
and Data Systems Support
Health Planning and Resources Development
CN 360, Room 602
Trenton, New Jersey 08625
(609) 292-0086-89

BACKGROUND IN NEW JERSEY

1974 - Governor Byrne, Commissioner of Health
Joanne Finley, M.D., M.P.H.

1975 - Standard Hospital Accounting and Rate Evaluation (SHARE) System implemented. Based on reasonable cost per day.

1976 - HCFA awarded NJSDOH contract to develop prospective reimbursement system using DRGs. Abstracts submitted to NJSDOH.

1977 - Billing regulation passed

1978 - Senate Bill S-446 passed. Experimental phase of DRGs. Rate calculations

1979 - ICD-9-CM coding implemented. National Committee began work on ICD-9-CM DRGs. Rates set for N.J. hospitals.

1980 - 26 hospitals on DRGs. Problems. URO Regulation passed.

1981 - Next 35 hospitals on DRGs. UB-PS regulation passed.

1982 - Remaining 36 acute care hospitals on DRGs. ICD-9-CM DRGs implemented starting June 1, 1982.

1983 - Refinement methodology. Federal contract ends

Diagnosis Related Groups (DRGs) in New Jersey

1. DRGs classify patients based upon their diagnosis, reason for admission to the hospital, plus other attributes.

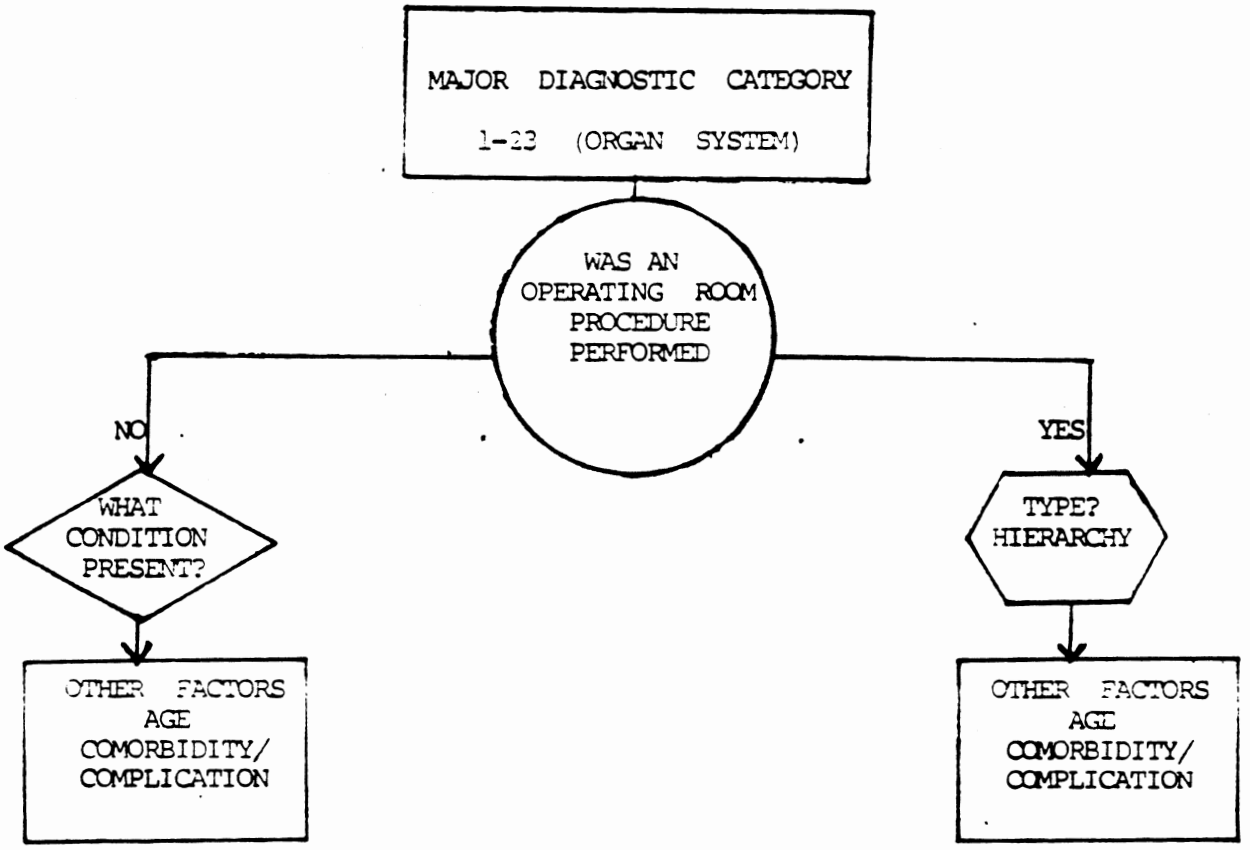
2. Patients in the same group, or DRG, are expected to consume similar resources, therefore, an average amount of resource consumption can be assigned to each group. The average amount is the DRG rate and a hospital is reimbursed a rate for each patient in each DRG.

3. The 467 DRGs were constructed from a data base consisting of 1.4 million medical discharge abstracts from a nationwide sample and 330,000 abstracts and cost records from New Jersey. There was a great deal of clinical input as well as statistical input into the 467 DRGs. New Jersey experts played a major role in the construction of the 467 DRGs.

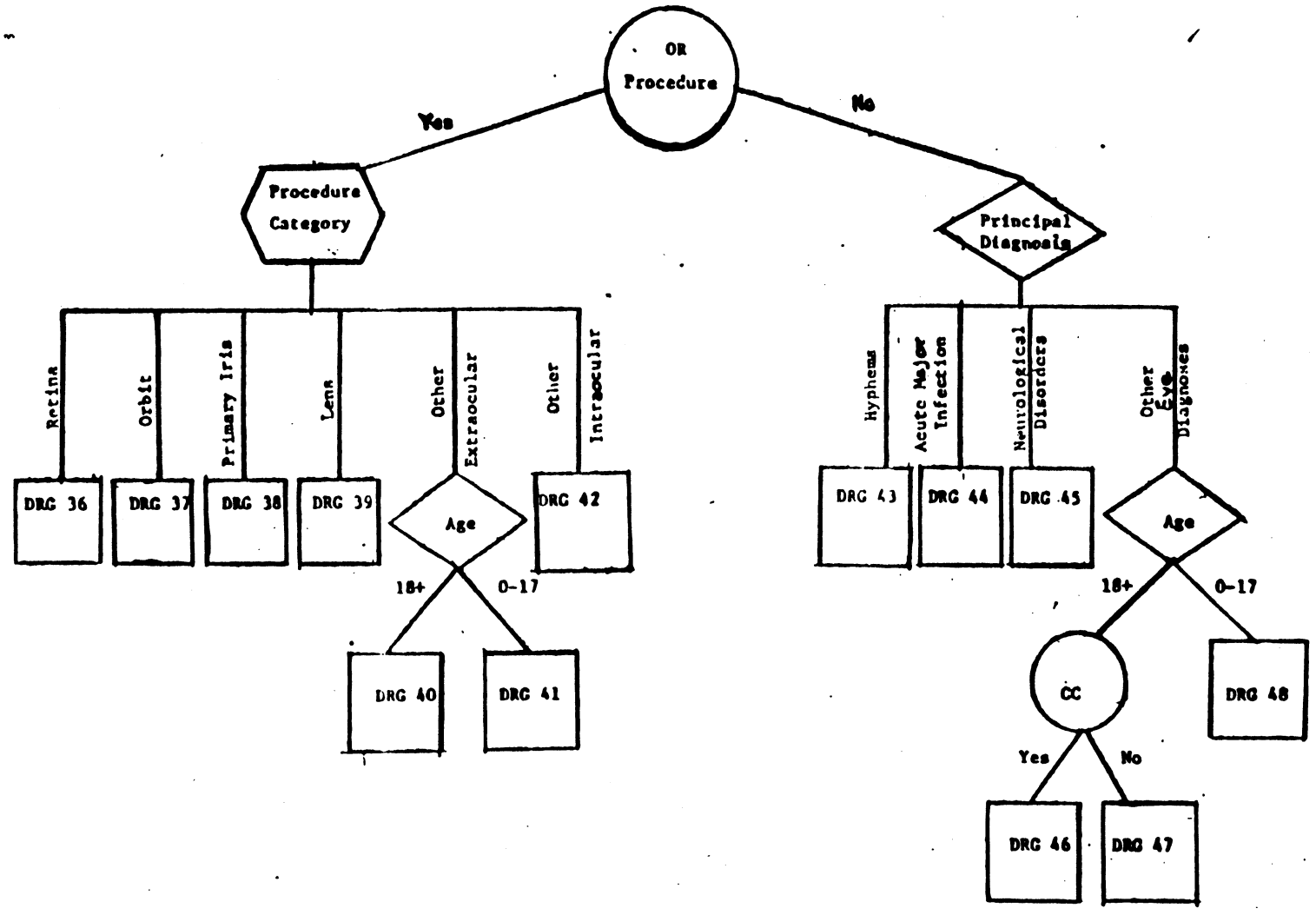
4. The DRGs were based on ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modification) codes. There are numeric codes for every diagnosis and procedure. All diagnosis codes are grouped into 23 broad categories called Major Diagnostic Categories (MDCs) based on organ systems. Each MDC is subdivided by variables, such as presence of an operating room procedure, age, secondary diagnoses, that made a difference in Length of Stay (LOS). The final groups were DRGs.

The next Page shows the general breakdown from MDC to DRG, and the actual diagram (tree) of MDC02, Diseases and Disorders of the Eye. The term "CC" means comorbidity/complication.

Following that page are verbal descriptions of complications, comorbidity, etc.


MAJOR DIAGNOSTIC CATEGORY
1-23 (ORGAN SYSTEM)
WAS AN OPERATING ROOM PROCEDURE PERFORMED
NO
YES
WHAT CONDITION PRESENT?
TYPE? HIERARCHY
OTHER FACTORS AGE COMORBIDITY/ COMPLICATION
OTHER FACTORS AGE COMORBIDITY/ COMPLICATION

MAJOR DIAGNOSTIC CATEGORY 02:
DISEASES AND DISORDERS OF THE EYE
Medical and Surgical Partitioning



cc=Comorbidity and/or Complication

EXAMPLES

COMPLICATIONS:	ACUTE MYOCARDIAL INFARCTION
	POST-OPERATIVE INFECTION
	PNEUMONIA
COMORBIDITY:	CHRONIC OBSTRUCTIVE LUNG DISEASE
	IRON DEFICIENCY ANEMIA
	CONGESTIVE HEART DISEASE
NEITHER COMPLICATION NOR COMORBIDITY:	ARTERIOSCLEROTIC HEART DISEASE
	DIABETES MELLITUS, UNCOMPLICATED, NON INSULIN DEPENDENT
	BENIGN PROSTATIC HYPERTROPHY
OPERATING ROOM PROCEDURE:	APPENDECTOMY
	MASTECTOMY
	CHOLECYSTECTOMY
NON OPERATING ROOM PROCEDURE:	CLOSED REDUCTION OF FRACTURE
	NASAL PACKING
	THORACENTESIS

DRG Assignment

DRG assignment is the basis for rate setting, patient billing and some management reports. The variables required for DRG assignment are as follows:

1. Principal diagnosis
2. Secondary diagnoses
3. Principal and other procedures
4. Age at admission
5. Sex of patient
6. Discharge status (transfer, left against medical advice, etc.)
7. Admission and discharge dates

A DRG can be assigned by hand or by computer (preferable). The above variables are selected by computer through the use of a program called GROUPER. All secondary diagnoses and all procedures are searched and the appropriate one(s) selected.

Once the DRG is assigned, outlier status is determined. In New Jersey, there are 7 categories of hospital inpatients considered atypical in terms of resource consumption or length of stay. The categories are listed below.

1. High length of stay outliers - patients whose length of stay was higher than the typical LOS for any DRG.
2. Low length of stay outliers - patients whose LOS was lower than the typical LOS for any DRG.
3. Patients who left against medical advice.
4. Patients who died.
5. Patients admitted and discharged on the same date.
6. Patients assigned to clinical outlier DRGs - DRGs with an assortment of patients.
7. Patients assigned to low volume DRGs - DRGs which had 5 or fewer patients in the base year and for which no rate was set.
8. Transfers.

All outliers are billed charges, not the DRG payment rate.

SETTING OF RATES

For 1980-1983 rate setting medical discharge abstracts, bills and cost data submitted by the hospitals were combined to obtain a cost per case. This number is manipulated by factors accounting for labor market area, urban-rural setting and teaching status. The result is a standard direct patient care cost per case for teaching, minor teaching and non-teaching hospitals.

A portion of the standard and a portion of each hospitals own cost for a given DRG are combined to give the direct patient care portion of the DRG payment rate for each DRG for each hospital.

The direct patient care payment rate is multiplied by a mark-up factor, specific for each hospital, to cover indirect costs. The mark-up factor is calculated by the Department.

At the time of billing, a payor factor, specific for the hospital and the payor covering the bill, and which includes payor differential and portion of indigent care is also applied. The payor factor is calculated by the Department.

To summarize -

Direct patient care portion
(% standard + % own cost)
x Mark-up factor
x Payor factor
= Amount billed inlier patient

Each hospital receives rates and financial elements and management reports. A hospital can appeal its rates, and works through the process with its analyst, the Department and the Rate Setting Commission.

Since rates, factors and DRG assignments are based on hospital supplied data, the data quality is extremely important. Errors in data mean delays and poor products.

Information Flow

The following Flow Chart illustrates a general flow of information within a hospital under the DRG system. All departments are involved in providing information which is needed for DRG assignment. The faster the information is collected, the sooner the patient can be billed.

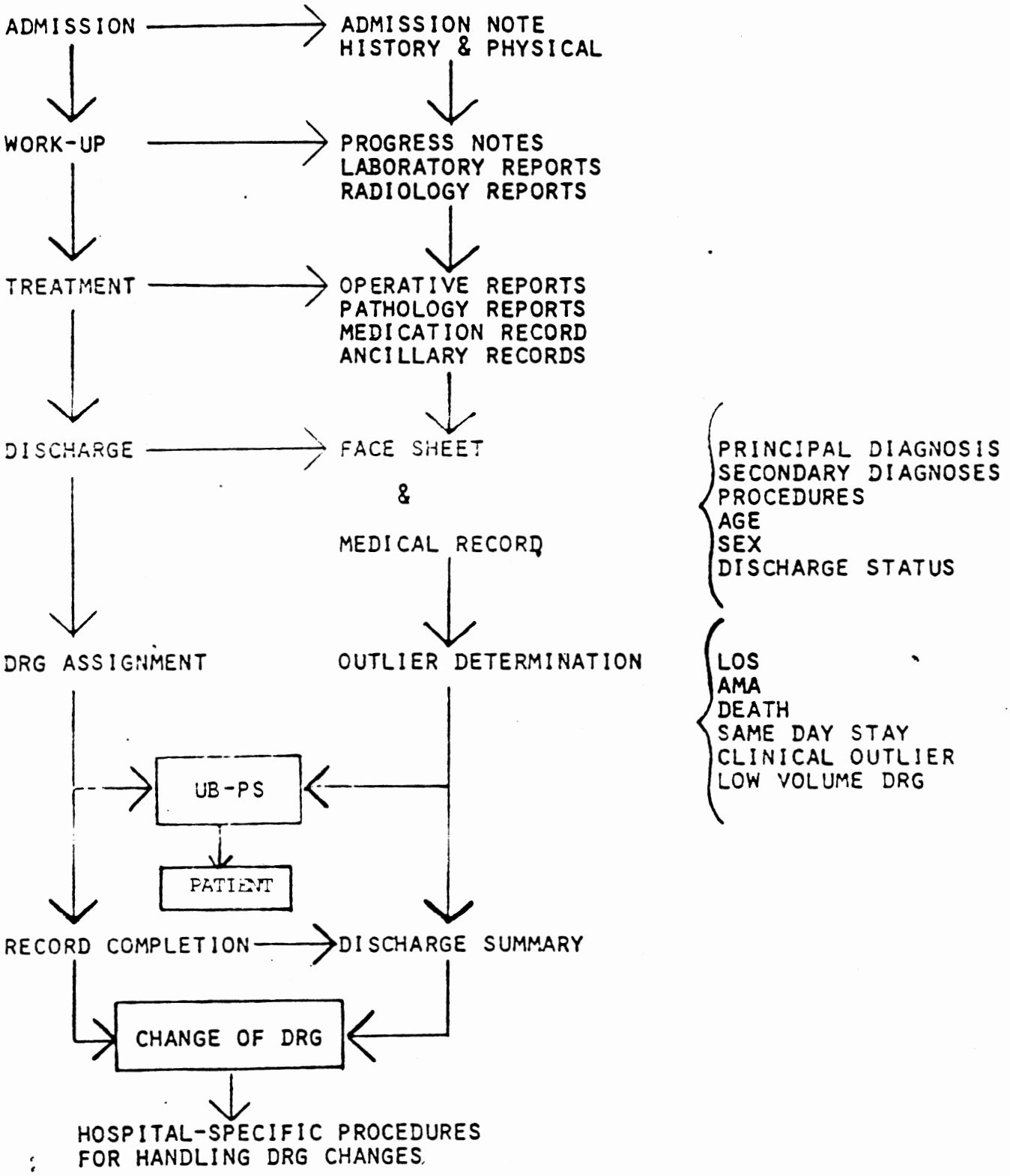
Accuracy of data and timeliness of data submission are extremely important. Education of all departments within a hospital is imperative. Each department must understand the DRG system and how it impacts. Physicians must understand that as the resource consumer of the hospital, they are responsible for the solvency of the institution.

Reports can be generated which will show unnecessary expenditures. Use of management reports in the financial and clinical areas can trim wasted money and allow the hospital to provide the best quality of care in the most efficient manner.

Once the patient is billed by the Uniform Bill-Patient Summary (UB-PS), insurance companies (payers) and utilization review organizations become involved in the DRG system in New Jersey. Payers are checking the claims for accurate DRG assignment, correct charges, etc. Utilization Review Organizations, in New Jersey the Professional Standard Review Organizations (PSROs), monitor quality of care either themselves or through delegation of that function to hospitals.

PSROs also are the first level of the patient appeal mechanism. The appeal mechanism is designed to protect patients from inequities in the DRG system. It was instituted primarily for self-pay patients, but serves other patients, payers and hospitals.

INFORMATION FLOW



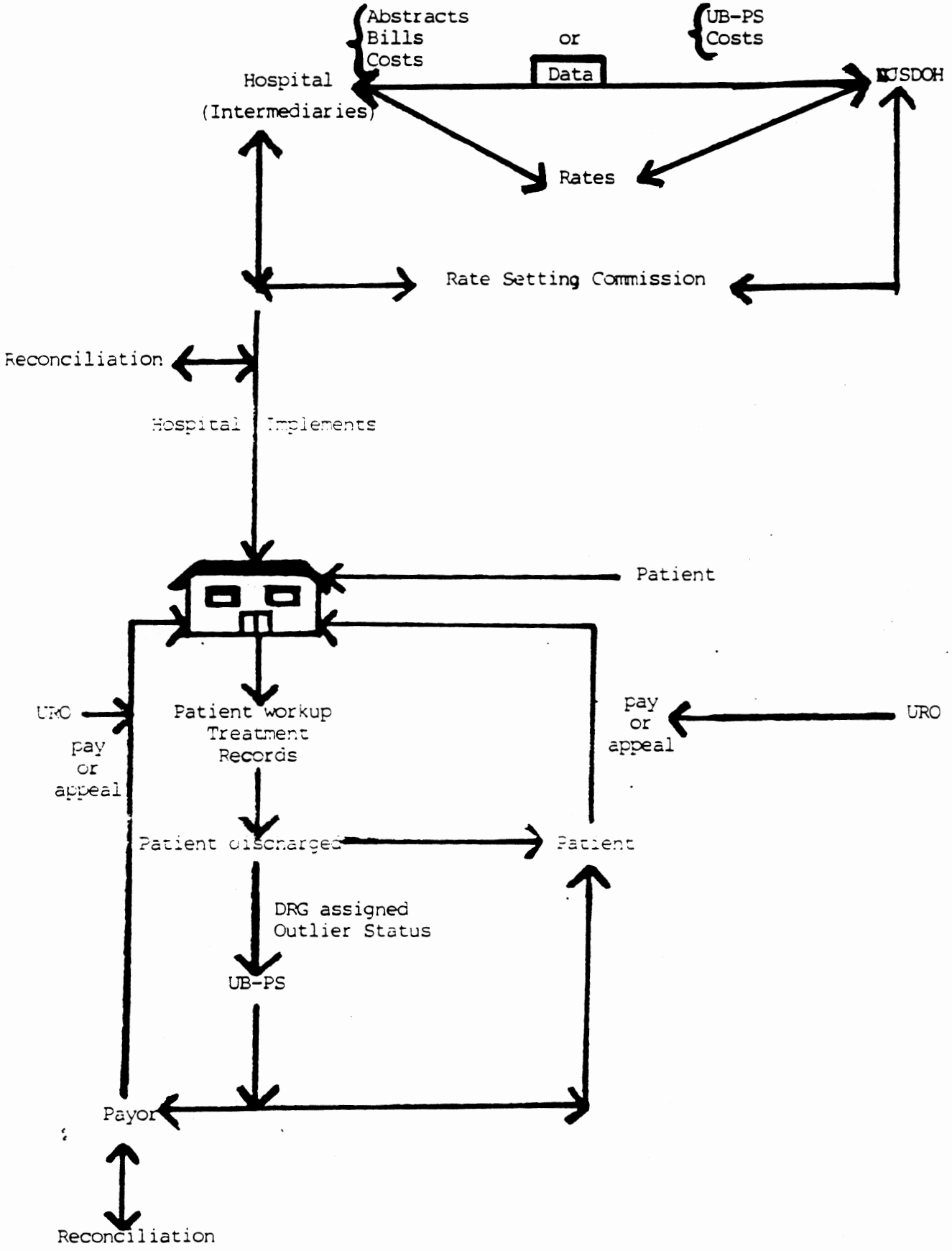
1. The allocation of resources is equitable and based on specific products. A hospital's reimbursement is closely tied to the clinical characteristics and volume of the patients it treats.

2. These resources can be used more effectively by increasing the efficient clinical and financial management. Hospitals have responded to the system by instituting and maintaining dialogue between all departments as a means of identifying and embarking on cost-saving, programs while maintaining high quality care.

3. There is equity across third party payors. All payors pay a portion of indigent care costs, which eliminates high differentials in premiums between different insurance companies.

4. Hospitals are covered for the cost of providing care to indigent patients. They can now concentrate on providing quality medical care to all patients irregardless of socio-economic status.

General Flowchart of the DRG System in New Jersey



GLOSSARY

1. AGAINST MEDICAL ADVICE (AMA): THE DISCHARGE STATUS OF PATIENTS WHO LEAVE THE HOSPITAL HAVING SIGNED A RELEASE FROM RESPONSIBILITY OR WHO LEAVE THE HOSPITAL PREMISES WITHOUT PRIOR KNOWLEDGE OF HOSPITAL PERSONNEL.

2. AUTOGROUP: AN INTERACTIVE STATISTICAL ANALYSIS SYSTEM WHICH ALLOWS PARTITIONING OF DATA (PATIENT RECORDS) SO AS TO EXPLAIN VARIATION IN SOME DEPENDENT VARIABLE AS A FUNCTION OF SOME SET OF INDEPENDENT VARIABLES (PATIENT ATTRIBUTES).

3. CASE-MIX: THE CLASSIFICATIONS OR CATEGORIES OF PATIENTS TREATED BY A HOSPITAL.

4. CHARGES: THE DOLLAR AMOUNT A HOSPITAL BILLS AN OUTLIER CASE BASED ON THE ITEMIZED BILL.

5. CLINICAL OUTLIER: CASES WHICH CANNOT ADEQUATELY BE ASSIGNED TO AND APPROPRIATE DRG DUE TO UNIQUE COMBINATIONS OF DIAGNOSES AND SURGERIES, VERY RARE CONDITIONS, OR FOR OTHER UNIQUE CLINICAL REASONS. SUCH CASES WILL BE GROUPED TOGETHER INTO "CLINICAL OULIER" DRGS, THUS WILL BE CONSIDERED OUTLIERS.

6. COMORBIDITY: A PRE-EXISTING CONDITION THAT WILL, BECAUSE OF ITS PRESENCE WITH A SPECIFIC PRINCIPAL DIAGNOSIS, CAUSE AN INCREASE IN LENGTH OF STAY BY AT LEAST ONE DAY IN APPROXIMATELY 75% OF THE CASES. ALSO REFERRED TO AS "SUBSTANTIAL COMORBIDITY."

7. COMPLICATION: A CONDITION THAT ARISES DURING THE HOSPITAL STAY THAT PROLONGS THE LENGTH OF STAY BY AT LEAST ONE DAY IN APPROXIMATELY 75% OF THE CASES. ALSO REFERRED TO AS "SUBSTANTIAL COMPLICATION."

8. DIAGNOSIS RELATED GROUPS: A PATIENT CLASSIFICATION SCHEME WHICH CATEGORIZES PATIENTS WHO ARE MEDICALLY RELATED WITH RESPECT TO DIAGNOSES AND TREATMENT, AND ARE STATISTICALLY SIMILAR IN THEIR LENGTHS OF STAY.

9. DISCHARGE STATUS: DISPOSITION OF THE PATIENT ON DISCHARGE.

10. DRG RATE: A FIXED DOLLAR AMOUNT BASED ON AVERAGING OF ALL PATIENTS IN THAT DRG IN THE BASE YEAR ADJUSTED FOR INFLATION, ECONOMIC FACTORS AND BAD DEBTS.

11. GROUPER: THE COMPUTER SOFTWARE (PROGRAM) WHICH ASSIGNS DRGS.

12. HOMOGENEOUS: CONSISTING OF PATIENTS CONSUMING SIMILAR TYPES AND AMOUNTS OF HOSPITAL RESOURCES.

13. LOOPING: THE GROUPER PROCESS FOR SEARCHING ALL LISTED DIAGNOSES FOR PRESENCE OF ANY COMORBID CONDITION OR COMPLICATION; OR SEARCHING ALL PROCEDURES FOR "OR PROCEDURES" OR MORE SPECIFIC PROCEDURES AS INDICATED ON THE TREE DIAGRAM.

14. LOW VOLUME DRGS: DRGS WITH FIVE OR FEWER PATIENTS IN A HOSPITAL'S BASE YEAR.

15. MAJOR DIAGNOSTIC CATEGORIES (MDCs): BROAD CLASSIFICATIONS OF DIAGNOSES. THERE ARE 83 CODING SYSTEM ORIENTED MDCS IN THE ORIGINAL DRGS, AND 23 BODY SYSTEM ORIENTED MDCS IN THE REVISED SET OF DRGS.

16. MAXIMIZATION: MANIPULATION OF DATA TO OPTIMIZE HOSPITAL REIMBURSEMENT.

17. OR PROCEDURE: OPERATING ROOM PROCEDURE - THOSE PROCEDURES PERFORMED IN A FULLY EQUIPPED OPERATING ROOM OR THOSE PROCEDURES DETERMINED BY THE PHYSICIANS AS BEING SIGNIFICANT IN TERMS OF DEGREE OF RISK OR RESOURCE CONSUMPTION. THE PHYSICIANS REVIEWED ALL ICD-9-CM PROCEDURE CODES AND CLASSIFIED EACH AS "OR PROCEDURE" OR "NON-OR PROCEDURE."

18. OR PROCEDURE HIERARCHY: RANKING OF ALL OR PROCEDURES IN TERMS OF DEGREE OF RISK OR RESOURCE CONSUMPTION. OR PROCEDURES ARE RANKED FROM LEFT TO RIGHT ON THE TREE DIAGRAMS WITH PRIORITY GIVEN TO THE LEFT-MOST PROCEDURES, I.E., A PATIENT WITH 2 OR MORE OR PROCEDURES WILL BE CLASSIFIED INTO THE LEFT-MOST APPLICABLE PROCEDURE CATEGORY. ALSO REFERRED TO AS "SURGICAL HIERARCHY."

19. OTHER DIAGNOSIS: ALL CONDITIONS THAT EXIST AT THE TIME OF ADMISSION OR DEVELOP SUBSEQUENTLY WHICH AFFECT THE TREATMENT RECEIVED AND OR THE LENGTH OF STAY. DIAGNOSES THAT RELATE TO AN EARLIER EPISODE WHICH HAVE NO BEARING ON THIS HOSPITAL STAY ARE TO BE EXCLUDED.

20. OUTLIERS: PATIENTS DISPLAYING ATYPICAL CHARACTERISTICS RELATIVE TO OTHER PATIENTS IN A DRG, I.E., LOW & HIGH LENGTH OF STAY, DEATH, LEAVING AGAINST MEDICAL ADVICE, ADMITTED AND DISCHARGED THE SAME DAY, CLINICAL OUTLIERS, AND LOW VOLUME DRGS.

21. PRINCIPAL DIAGNOSIS: THE CONDITION ESTABLISHED AFTER STUDY TO BE CHEIFLY RESPONSIBLE FOR OCCASIONING THE ADMISSION OF THE PATIENT TO THE HOSPITAL FOR CARE.

22. PRINCIPAL PROCEDURE: ONE WHICH WAS PERFROMED FOR DEFINITIVE TREATMENT RATHER THAN ONE PERFORMED FOR DIAGNOSTIC OR EXPLORATORY PURPOSES, OR WAS NECESSARY TO TAKE CARE OF A COMPLICATION. THE PRINCIPAL PROCEDURE IS THAT PROCEDURE MOST RELATED TO THE PRINCIPAL DIAGNOSIS.

23. PROSPECTIVE REIMBURSEMENT: A PAYMENT METHOD IN WHICH HOSPITAL RATES ARE SET PROSPECTIVELY - BEFORE SERVICES ARE RENDERED AND ARE BASED UPON EXPECTED CLASSES AND VOLUMES OF PATIENTS.

24. UNIFORM BILL-PATIENT SUMMARY: DOCUMENT WHICH COMBINES BILLING INFORMATION AND MEDICAL DATA.

25. UNIFORM HOSPITAL DISCHARGE DATA SET (UHDDS): A MINIMUM BASIC GROUP OF ITEMS FOR HOSPITAL DISCHARGE ABSTRACTS RECOMMENDED BY THE UNIFORM HOSPITAL ABSTRACT SUBCOMMITTEE OF THE UNITED STATES NATIONAL COMMITTTEE ON VITAL AND HEALTH STATISTICS.

ATTACHMENT E

CORRESPONDENCE BETWEEN

THE DEPARTMENT OF HEALTH AND

INTERESTED PARTIES ON PSYCHIATRIC DRGs

Y. Goldschmidt

State of New Jersey

DEPARTMENT OF HEALTH
JOHN FITCH PLAZA
CN 360, TRENTON, N.J. 08625

Allen N. Koplin, MD, MPH
Acting
COMMISSIONER

October 18, 1982

Sister Nora Molyneux
Administrator
Holy Name Hospital
718 Teaneck Road
Teaneck, NJ 07666

Dear Sister Nora:

Doctor Mayer had referred your letter dated September 10, 1982, to me. Unfortunately, Doctor Mayer's office did not receive the letter until September 22, so an earlier response was not possible.

As I understand the incident that prompted your letter, the patient's principal diagnosis was "Major depressive disorder, single episode", ICD-9-CM code 296.20. At the time of this patient's hospitalization, the old 383 DRGs were in use. Based on that principal diagnostic code, the patient went into DRG 90. The title of DRG 90 was "Schizophrenia (Affective, Acute Episode), Manic-Depressive Psychosis."

As has been stated many times, the titles of the old DRGs did not reflect all the patients within that DRG. The titles are to be used for hospital internal management purposes. The titles are not meant to be used on the Uniform Bill-Patient Summary (UB-PS).

I understand that Holy Name Hospital puts the DRG titles on the UB-PS. Titles are not required on the UB-PS, and their use can lead to problems. Holy Name Hospital seems to be the only hospital which includes the DRG title on the UB-PS.

The data required on the payor copy of a UB-PS is the principal diagnosis description. In this case, it is "Major depressive disorder, single episode." That English descriptive and its code, and codes for other diagnoses, if any, and the same for procedures, are the only diagnostic information that should be on any UB-PS going from a hospital to a payor. Even this information should be deleted on the patient copy (UB-PS Regulations, p. III-1). In your letter, you intermix the terms, title and diagnosis which have different meanings.

I would suggest that Holy Name Hospital immediately stop including DRG titles on their UB-PS forms. If you do, then most of your concern about patients being "misclassified" disappears. The only thing on the UB-PS would be the physician's diagnoses, which should accurately reflect the patient's condition.

When Faith Goldschmidt of my staff talked to Doctor Carluccio, she told him that ICD-9-CM code 296.20 is listed in the ICD-9-CM book, under the broad heading "Psychoses". The Department of Health, as well as the hospitals, must work within the confines of the ICD-9-CM classification scheme's arrangement of diagnoses. It was suggested that the psychiatric specialty society contact and work with the ICD-9-CM committee in Ann Arbor, Michigan, if the committee feels that "Major depressive disorder, single episode" is not a psychoses. Other specialty societies are working with the ICD-9-CM committee to refine diagnoses for future use. I would like to stress that the Department worked with New Jersey psychiatrists in developing the new DRGs, and I have attached a list of the participants at the physician review session of Major Diagnostic Category 5, "Mental Disorders".

As to the action which the hospital proposes, I believe that a statement such as on page 2 of your letter is unnecessary if the DRG titles are not included on the UB-PS. While the Department is reviewing the I-9 DRGs, it is not accurate to state "Please note that the above DRG is currently undergoing revision and may not in fact properly categorize this patient's illness."

It is unfortunate that this incident occurred, which may have been avoided if the DRG titles were not included on the Uniform Bill-Patient Summary. If you would like to discuss this further, please do not hesitate to call me at (609) 292-8772.

Sincerely,

Joseph I. Morris
Acting Assistant Commissioner
Health Planning and
Resources Development

JIM/ams
Attachment
cc: Faith Goldschmidt
NJ State Psychiatric Association

MDC 05

Mental Disorders

Physician Review Session

Participants

Michael Alpert, M.D. (Psychiatry) St. Clare's Hospital
James Cowan, M.D. (Psychiatry) East Orange General Hospital
Robert K. Davies, M.D. (Psychiatry) Fair Oaks Hospital
Jack B. Krenens, M.D. (Psychiatry) Monmouth Medical Center
Irwin N. Perr, M.D. (Psychiatry) Rutgers CMDNJ
Warren B. Nestler, M.D. (Internal Medicine) Overlook Hospital
Jamie Horn (Administration/Psychiatry) East Orange General Hospital
Joan Loughran, Medical Records, Medical Center at Princeton
Marcia Stachyra, R.N., Ph.D., Psychiatric Nursing,
Rutgers College of Nursing

Joanne E. Finley, M.D., M.P.H., NJ State Department of Health
Leo K. Lichtig, Ph.D., NJ State Department of Health
Faith K. Goldschmidt, NJ State Department of Health
Larry L. Eitel, NJ State Department of Health

Holy Name Hospital

718 TEANECK ROAD

TEANECK, N.J. 07666

OFFICE OF ADMINISTRATOR

AREA CODE (201) 833-3205

September 10, 1982

RECEIVED

Shirley Mayer, M.D.
Commissioner of Health
State Department of Health
John Fitch Plaza
CN 367
Trenton, NJ 08625

Dear Dr. Mayer:

We wish to bring to your attention a recent incident in our institution which concerns the allocation of a psychiatric diagnosis to an inappropriate D.R.G. group. We believe that this incident may illustrate a deficiency in the classification (for D.R.G. purposes) of psychiatric diagnoses which may have state-wide implications.

A 20 year old female, with no prior history of psychiatric hospitalizations, was admitted to Holy Name Hospital for treatment of depression. There was no history of psychotic symptoms associated with the patient's illness.

One day after admission, the patient signed out of the hospital against medical advice but with an improvement noted in her depressive symptoms. A discharge diagnosis of "Major Depression" (ICDA 296.20) was coded in our record room. This in turn resulted in D.R.G. #90 (schizophrenia, affective, acute episode, manic depressive psychosis) being assigned to this case for reimbursement purposes. Titles were used.

The diagnosis of schizophrenia was forwarded to the patient's insurance company and has now become part of that company's medical data base for the patient. Needless to say this has caused consternation both on the part of the patient and her parents (both of whom are health care professionals).

I am informed by the patient's attending physician (the former Chief of Psychiatry at our hospital) that there is no clinical basis for the assignment of a schizophrenic diagnosis to this patient.

It wasn't a schiz Dx

After further inquiries, I was informed by our Director of Medical Records that because of recent state-wide changes in the D.R.G. classification system a patient now discharged with the diagnosis of "Major Depression" would be coded into D.R.G. 430 "Psychosis, medical."

We understand that any reductive system of patient classification runs the potential risk of misclassifying certain patients into incorrect diagnostic groupings. However, we feel that the translation (until recently) of "Major Depression" as a diagnosis into a "schizophrenia" D.R.G. may have caused a significant number of incorrect and potentially harmful diagnoses to be encoded for patients receiving psychiatric treatment in New Jersey hospitals during the first years of the D.R.G. demonstration project. Additionally, members of our psychiatric department feel that the use of D.R.G. 430 (Psychosis, Medical), while an improvement over the previous coding system, still represents an incorrect classification for these patients. Therefore, the problem remains unresolved at the moment.

We are sure that you will want to have your staff inquire further into this matter.

We would suggest, at minimum, that your office inform all health insurers in New Jersey that patients billed under D.R.G. 90 in the past may have been misclassified inappropriately as being "schizophrenic". This is necessary to correct the health insurance records of patients who may now have damaging (and inaccurate) data in their insurance claims files.

To protect patients currently being discharged from our hospital's psychiatric ward, we intend to inform insurers that patients coded under D.R.G.'s 426, 427, and 430 may be inappropriately categorized. Accordingly, we intend to print the following on the uniform billing statement:

> Please note that the above D.R.G. is currently undergoing revision and may not in fact properly categorize this patient's illness. The discharge diagnosis given this patient by the attending physician was _____.

~~Because this constitutes a unilateral change of the State's mandated billing process, we will delay its implementation for 15 days to permit you to review our intended course of action and to advise us accordingly.~~

If we can be of any further assistatnce, please do not hesitate to call.

Sincerely,

Sister Nora Molyneux

Sister Nora Molyneux
Administrator

SNM/jgf
c-N.J. State Psychiatric Association

May 14, 1985

Charles Carlaggio, M.D.
[illegible] Boyle and Post
West New York, NJ [illegible]

Dear Dr. [illegible]:

I'm sorry for the delay in responding to your [illegible] in the [illegible] conversation of April 26, 1985, but I wanted to check on two of the issues.

You raised several issues. The first issue was whether or not Holy Name Hospital is still putting the DRG title on the Bill (Uniform Bill-Patient Summary, UB-PS). I have checked that with the hospital and have been informed that DRG titles are no longer on any UB-PS form. I think this has been true since the incident several years ago.

Second, it is a federal requirement, as well as a state requirement, that principal diagnosis and principal procedure ICD-9-CM codes and English descriptions be inserted onto the UB-PS. For secondary diagnoses and procedures, only the ICD-9-CM codes are required.

The reason for inclusion of those two English descriptions is so that payers can determine whether or not the DRG assigned is reasonable. Instead of requiring English descriptions on all diagnoses and procedures, a compromise was struck that only principal diagnosis and procedure English descriptions were necessary.

This brings up the applicability of ICD-9-CM codes and English descriptors for psychiatric diagnoses. This is a third issue, and one over which the Department has no control. I believe I suggested, several years ago, that you and/or the specialty society contact the ICD-9-CM Committee in Ann Arbor, Michigan. Now the contact is as follows:

Prospective Payment Assessment Commission
Suite 301B
300 Seventh Street, S.W.
Washington, D.C. 20024

[illegible]

The fourth issue, grouping of the pediatric cases into the present DRGs, is another issue that should be brought to ProPAC's attention. In previous years, I had referred DRG construction issues to Health Systems [illegible], New Haven, Connecticut. There were probably not very many pediatric records from the acute care general hospital [illegible] used in the construction of the present DRGs. Therefore, differences in length of stay or resource consumption would not have been obvious at a level more detailed than the present DRGs.

The Department of Health does have the authority to change trim points, payment rate or outlier status. But it has no authority over ICD-9-CM coding designations or DRG construction.

I hope this letter addresses your concerns. Just let me repeat that I'm sure that ProPAC would be interested in your, your colleagues', and the specialty societies' input on the ICD-9-CM coding and DRG construction issues.

Sincerely,

Faith K. Goldschmidt
Director Designate
Systems Analysis, Development
and Data Systems Support
HEALTH PLANNING AND RESOURCES DEVELOPMENT

FKG:ms

May 14, 1985

Prospective Payment
Assessment Commission
Suite 301B
300 7th St. S.W.
Washington, D.C. 20024

Dear Sir/Madam:

Over the past few years, I have been dealing with [illegible] part of psychiatrists in New Jersey about the psychiatric DRGs. I have been advising the psychiatrists to make their concerns known to PPAC. In previous years, I advised them to contact Health Systems International (HSI) and the Health Care Financing Administration (HCFA).

Some of the issues are specific to New Jersey's DRG system. The two issues that are not, and over which the State of New Jersey has no authority or control, are use of ICD-9-CM codes for psychiatric diagnoses, and grouping of those codes into DRGs.

Before I continue, I should explain that New Jersey includes psychiatric patients in the acute care setting in its DRG system. The patient in a psychiatric unit within an acute care hospital is billed an average rate per case under New Jersey's DRG system.

First, many psychiatrists have indicated that ICD-9-CM codes do not capture the nuances of psychiatric diagnoses. They feel that more study and a revision of this set of codes should be done. On this issue, I have referred the psychiatrists also to the ICD-9-CM Committee in Ann Arbor, Michigan, in the hopes that the next set of codes, ICD-10-CM, might resolve this issue.

Second, the construction of the psychiatric DRGs is an issue. Psychiatrists feel that the groupings of specific ICD-9-CM codes into DRGs is not homogenous. I usually explain that since the data base used for construction of these DRGs consisted of records from acute care general hospitals, there probably were not enough records of psychiatric patients to show statistical differences in length of stay and cost at a more finite level below the present DRG groups. The psychiatric DRGs, themselves,

[illegible], [illegible] a [illegible] a [illegible].

If you have questions or would like the [illegible], please contact me.

Sincerely,

Faith K. Goldschmidt

Faith K. Goldschmidt
Director Data Base
Systems Analysis, Data Management
and Data Software Support
HEALTH PLANNING AND RESOURCES DEVELOPMENT

FKG:ms

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
300 7th Street, S.W. Washington, D.C. 20024 (202) 453-3986

Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

May 23, 1985

Faith K. Goldschmidt, Director Designate
Systems Analysis, Development
and Data Systems Support
Health Planning and Resources Development
John Fitch Plaza
CN 360, Trenton, New Jersey 08625

Dear Faith:

I am writing in response to your May 14 letter to the Prospective Payment Assessment Commission regarding the psychiatric DRGs. Other than your letter, we have not received correspondence on this issue. However, we understand that there are concerns with the DRG. HCFA is also aware of the problem and has a study underway regarding prospective rate-setting for Medicare patients in general hospital psychiatric units and psychiatric hospitals. It is our understanding that no changes in the system will be made until completion of the study. The Commission is monitoring efforts in this area and will also await the study results prior to recommending any changes.

Thank you for bringing your concerns to the Commission's attention.

Sincerely yours,

Mary Kaye Willian, DrPH

ATTACHMENT F

FINANCIAL AND CLINICAL DATA

FOR PSYCHIATRIC DRGs

F-1

1980 UB-PS RECORDS

26 DRG HOSPITALS

DRG NO.	TRIM POINTS (DAYS)	TITLE	INLIER CASES	OUTLIER CASES	INLIER CHARGES	OUTLIER CHARGES
88	2-90	Schizophrenia w/ psych. service	70	2	145,805	29,475
89	2-33	Schizophrenia w/o psych. service	2,581	34	5,198,778	305,047
90	3-37	Schizophrenia, Manic Depr.	1,540	6	3,807,455	101,033
91	2-20	Neurosis (anxiety, etc.)	577	7	705,420	45,198
92	2-24	Neurosis (depressive, etc.)	2,028	6	3,450,694	55,409
95	2-19	Psych. disorder	805	9	1,088,752	93,691
96	4-43	Psychosis	852	23	2,022,277	508,393
Total Psychiatric Records			8,453 (8,540)	87 (1%)	16,419,181	1,138,246
Total Records			367,978 (380,457)	12,479 (3.3%)		

The outliers in 1980 were length of stay outliers only. These DRGs were the old 383 DRGs in use in New Jersey in 1980 and 1981. Psychiatric records composed 2.2% of total UB-PS records received.

F-2

1981 UB-PS RECORDS

ALL DRG HOSPITALS

DRG NO.	TRIM POINTS (DAYS)	TITLE	INLIER CASES	OUTLIER CASES	INLIER CHARGES	OUTLIER CHARGES
88	2-1	Schizophrenia w/ psych. service	4	2	5,137	12,754
89	2-33	Schizophrenia w/o psych. service	4,816	731	11,117,362	2,424,301
90	2-33	Schizophrenia, Manic Depr.	3,245	511	9,859,089	2,875,610
91	2-15	Neurosis (anxiety, etc.)	855	254	1,136,746	438,497
92	2-24	Neurosis (Depressive, etc.)	2,988	680	5,688,325	1,768,925
95	2-15	Pych. disorder	1,329	408	2,346,340	859,703
96	2-12	Psychosis	1,277	832	2,019,670	4,850,428
Total Psychiatric Records			14,514 (17,932)	3,418 (19.1%)	32,172,669	13,230,218
Total Records			919,571 (1,141,944)	224,373 (19.6%)		

The outliers in 1981 were length of stay outliers only. Trim points changed from 1980. These DRGs were the old 383 DRGs in use in New Jersey in 1980 and 1981. Psychiatric records composed 1.6% of the total UB-PS records received.

F-3

1982 UB-PS HOSPITALS

ALL DRG HOSPITALS

DRG NO.	TRIM POINTS (DAYS)	TITLE	INLIER CASES	OUTLIER CASES	INLIER CHARGES	OUTLIER CHARGES	
*424	5-35	Mental dis., OR procedure	282	173	0	2,734,924	(For 455 records)
425	2-12	Acute, adjust, reactions, dysfunctions	1,097	422	1,233,673	1,057,511	
426	2-20	Neuroses, Dx1 depress. neur.	3,175	1,218	5,285,512	3,635,203	
427	2-17	Neuroses, no Dx1 depress. neur.	570	188	648,467	513,045	
428	2-24	Personality disorders, impulse control	539	218	833,029	1,098,709	
429	3-18	Organic disturbances, regard.	1,037	632	2,023,421	4,634,257	
430	3-33	Psychoses	10,550	2,963	26,447,083	13,422,661	
431	1-15	Childhood disorders	153	95	95,053	898,231	
*432	2-26	Other mental disorders	50	21	0	134,943	(For 31 records)
Total Psychiatric Records			17,453 (23,383)	5,930 (25.4%)	36,566,238	28,129,484	
Total Records			898,320 (1,188,142)	289,822 (24.4%)			

*Clinical Outlier DRGs

The outlier categories for Total Psychiatric Records include length of stay outliers, deaths, left against medical advice, same day stays. Clinical outliers, and low volume outliers are calculated later. For the psychiatric records, all records and dollars in DRGs 474 and 432 can be considered outlier records and dollars. The outlier categories for Total Records are those above with the exceptions noted. Psychiatric records composed 2.0% of the total UB-PS records.

F-4

1983 UB-PS RECORDS

ALL DRG HOSPITALS

DRG NO.	TRIM POINTS (DAYS)	TITLE	INLIER CASES	OUTLIER CASES	INLIER CHARGES	OUTLIER CHARGES
*424	5-35	Mental dis., OR procedure	321	193	1,568,082	2,251,454
425	2-12	Acute, adj. reactions, dysfunctions	1,058	421	1,515,466	1,170,294
426	2-20	Neuroses, Dxl depress. neur.	2,773	1,088	5,262,591	3,446,410
427	2-17	Neuroses, no Dxl depress. neur.	571	228	953,294	676,145
428	2-24	Personality, impulse control disorders	566	221	1,294,934	1,354,808
429	3-18	Organic disturbances, retard.	992	556	2,309,151	4,340,679
430	3-33	Psychoses	11,127	3,196	32,531,586	15,780,326
431	1-15	Childhood disorders	175	99	294,566	1,674,675
*432	2-26	Other mental disorders	43	23	70,569	43,262
Total Psychiatric Records			17,626	6,025 (23,651) (25.5%)	45,800,239	30,738,053
Total Records			896,739 (1,220,187)	323,448 (26.5)		

*Clinical Outlier DRGs

The outlier categories for Total Psychiatric Records include length of stay outliers, deaths, left against medical advice, same day stays. Clinical outliers and low volume outliers are calculated later. For the psychiatric records, all records and dollars in DRGs 427 and 432 can be considered outlier records and dollars. The outlier categories for Total Records are those above with the exceptions noted. Psychiatric records composed 1.9% of the total UB-PS records.

F - 5

General Hospital Acute Psychiatric Units

Utilization Trends*

YEAR	NO. OF UNITS	NO. OF BEDS	ADMISSIONS	PATIENT DAYS	AVG. LOS	OCCUPANCY
1980	38	929	18,761	265,465	14.1	78.1%
1981	40	961	20,425	272,097	13.3	78.0%
1982	40	961	19,544	280,190	13.7	79.9%
1983	41	1000	19,717	279,486	12.6	76.6%
1984	44	1051	N/A	N/A	N/A	N/A

* From medical discharge abstracts, center for Health Statistics, New Jersey State Department of Health.

Bergen Pines is excluded and admissions also may include patients admitted for alcohol or drug abuse.

F-6

1982 BASE YEAR DATA**

DIRECT PATIENT CARE (DPC) STANDARDS

TRIMMED DRGs (OUTLIERS EXCLUDED)

DRG NO.	TRIM POINTS (DAYS)	TITLE	MAJOR TEACHING STANDARD $	MINOR TEACHING STANDARD $	NON TEACHING STANDARD $
*424	5-35	Mental dis., OR procedure	-	-	-
425	2-12	Acute, adj. reactions, dysfunctions	787	774	697
426	2-20	Neuroses, Dxl depress. neur.	1,018	968	923
427	2-17	Neuroses, no Dxl depress. neur.	780	792	810
428	2-24	Personality, impulse control disorders	1,171	998	990
429	3-18	Organic disturb., regard.	1,231	1,254	1,258
430	3-33	Psychoses	1,605	1,617	1,348
431	1-15	Childhood disorders	642	771	641
*432	2-26	Other mental disorders	-	-	-

*Clinical DRGs
**Taken from 1982 Standard file

For purposes of comparison between DRGs and peer groups, only the PPC standard was used. No indirect costs are included. Final rates are hospital specific.

ATTACHMENT G

LENGTH OF STAY GRAPHS

FOR 468 DRGs -

1979, 1982, 1983 DATA

NOTE: The first page is total patients and average length of stay for all 3 years, state-wide. In each DRG, the first graph is number of cases, and the second graph is percent of cases, discharged on each day. The high day value was cut off to avoid running cnto several pages.

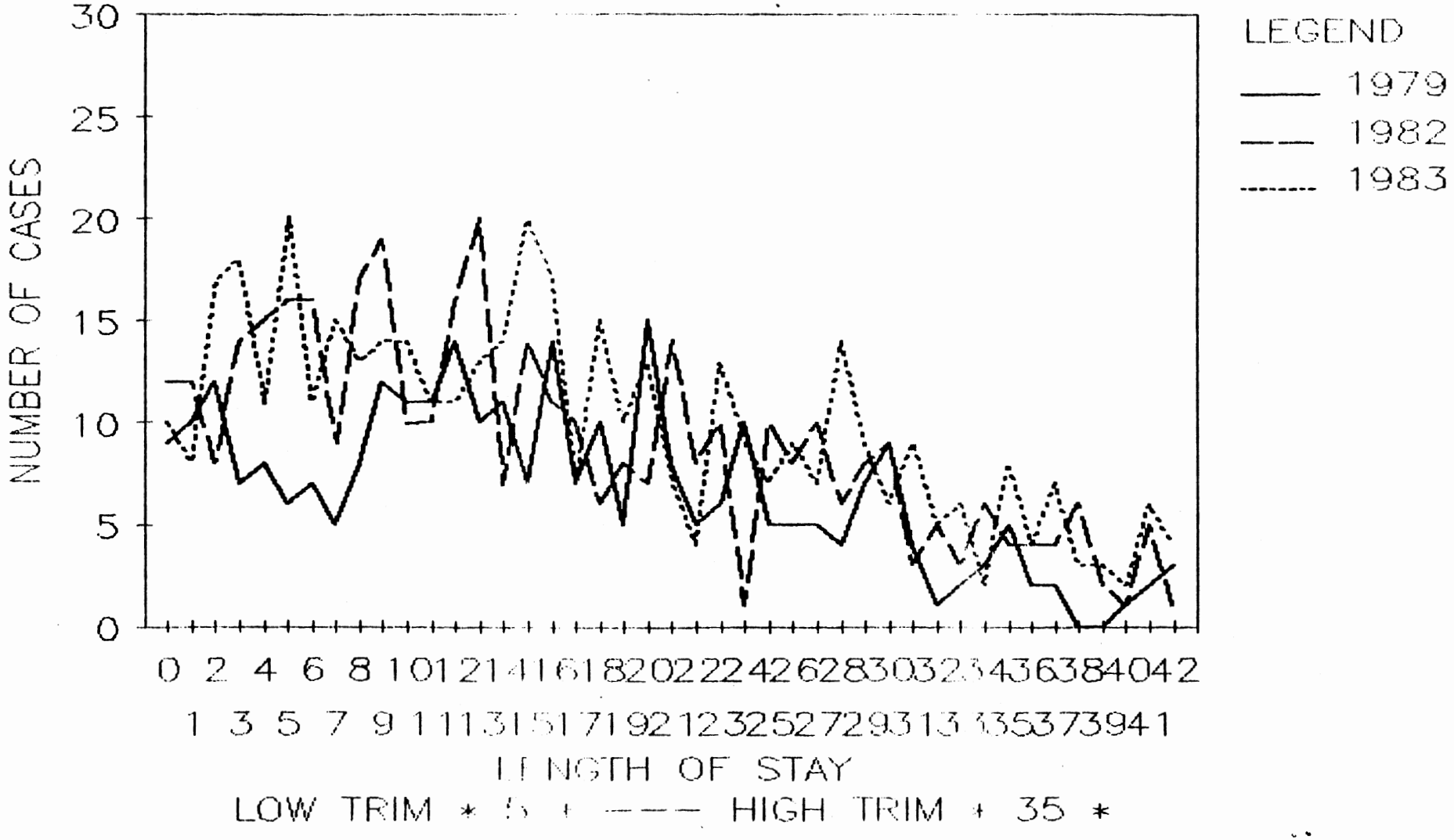
TOTAL PATIENTS AND AVERAGE LENGTH OF STAY

PSYCHIATRIC DRGS - (STATEWIDE / UNTRIMMED)

	TOTAL PATIENTS			AVERAGE LENGTH OF STAY		
	1979	1982	1983	1979	1982	1983
DRG 424	345	455	499	26.24	27.92	25.01
DRG 425	1698	1519	1499	7.14	7.12	6.87
DRG 426	4841	4393	3859	11.12	10.22	10.03
DRG 427	734	758	789	8.69	8.37	8.23
DRG 428	544	757	793	12.11	13.46	14.48
DRG 429	1697	1669	1571	20.90	19.41	18.73
DRG 430	9913	13513	14340	15.84	16.06	16.00
DRG 431	176	248	268	12.40	22.97	24.09
DRG 432	155	71	62	10.97	8.83	5.82
GRAND TOTAL =	20103	23383	23680			

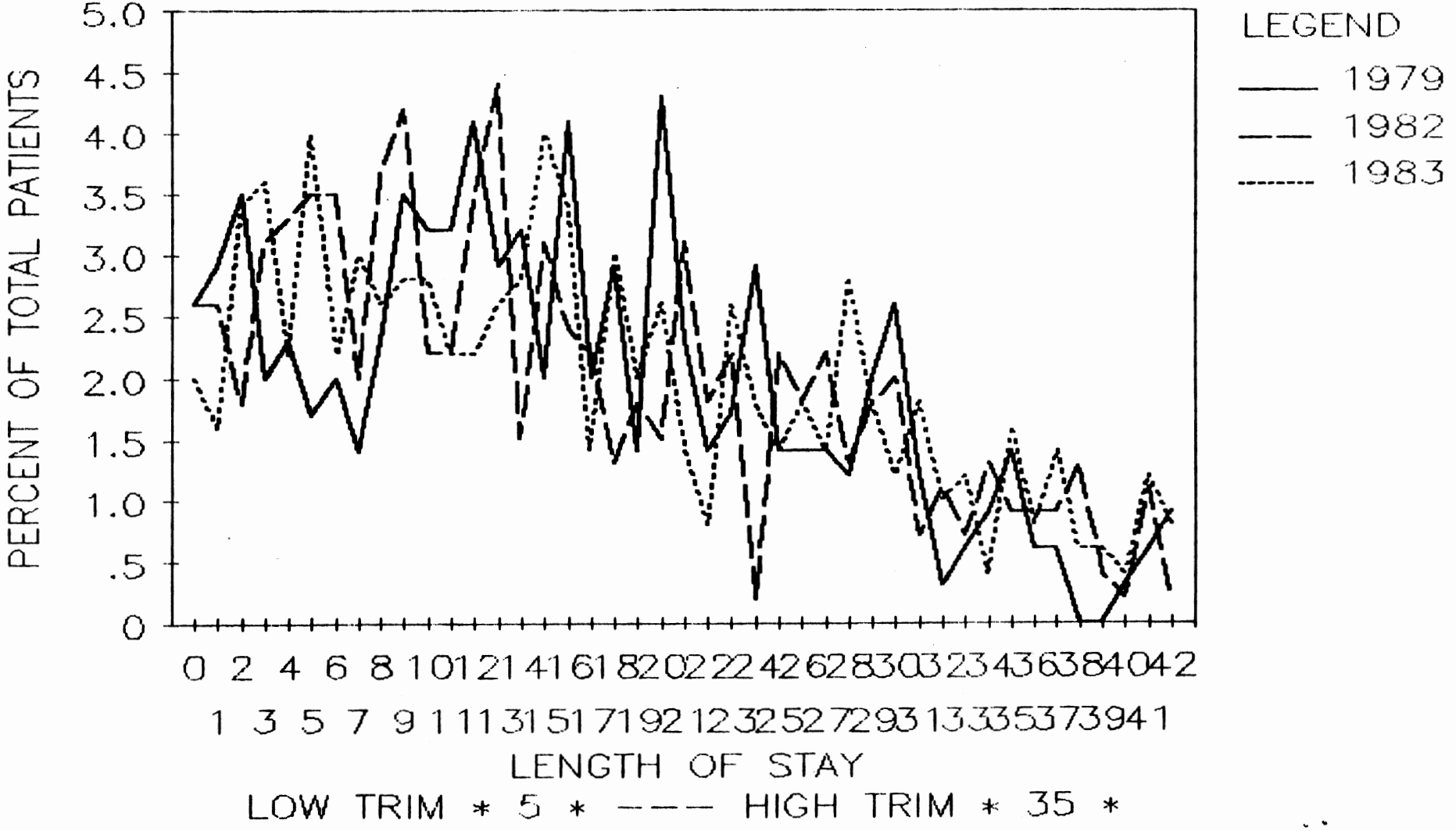
NOTE: AVERAGE LENGTH OF STAY WAS NOT TOTALED ACROSS YEARS OR DRGS BECAUSE OF THE DISPARITY BETWEEN YEARS AND DRGS.

DRG 424
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



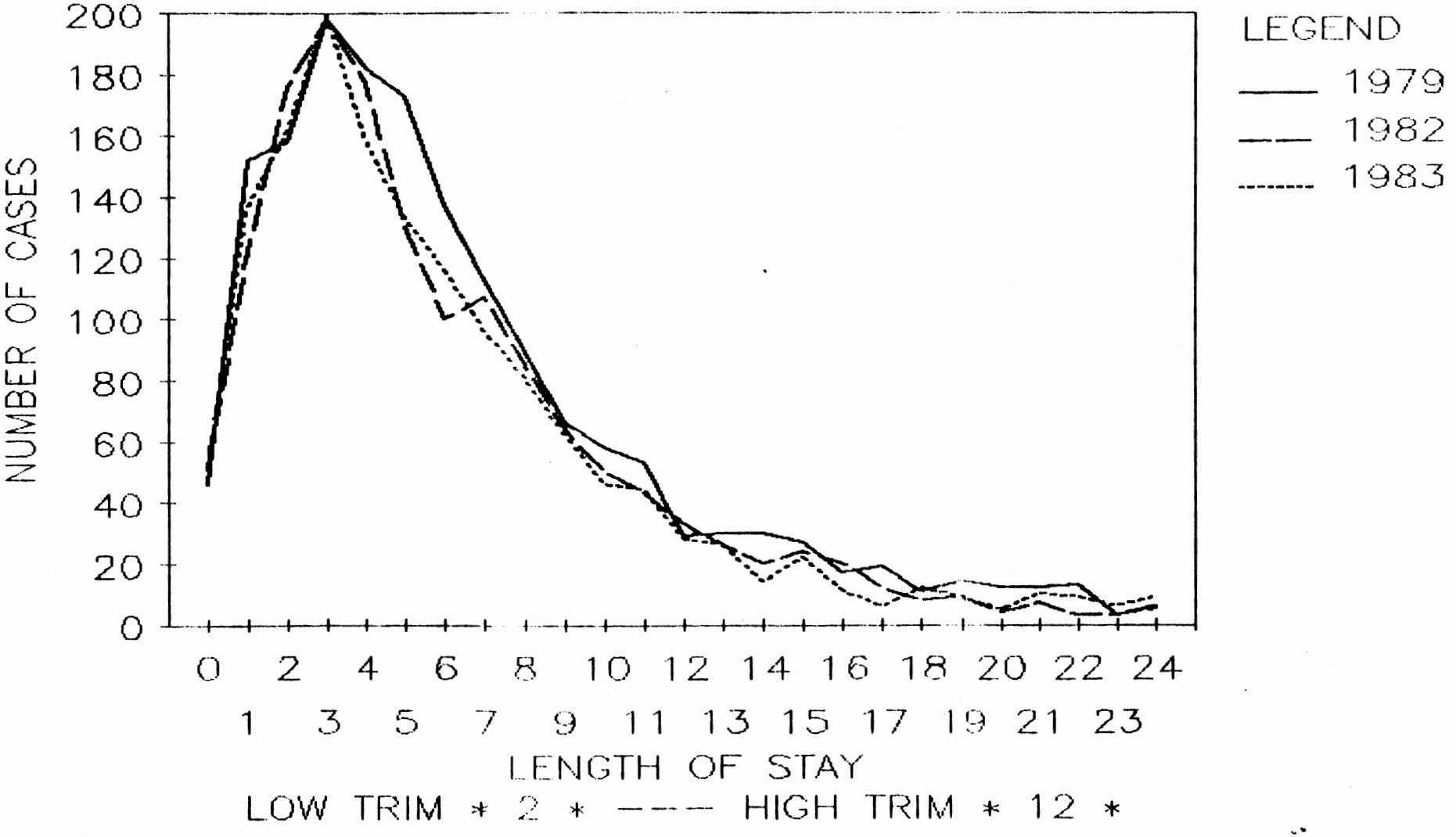
NJDOH

DRG 424
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



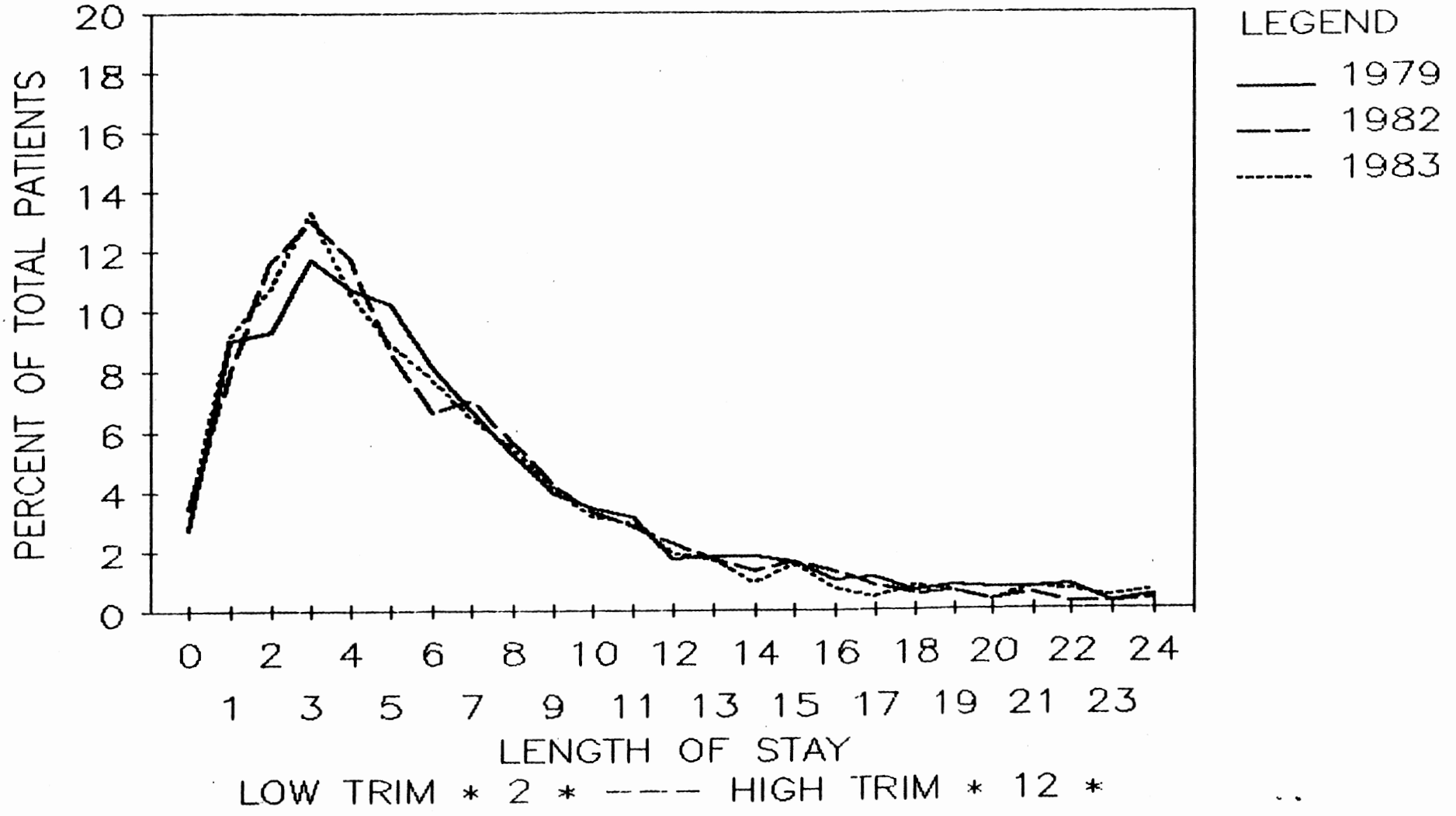
NJDOH

DRG 425
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



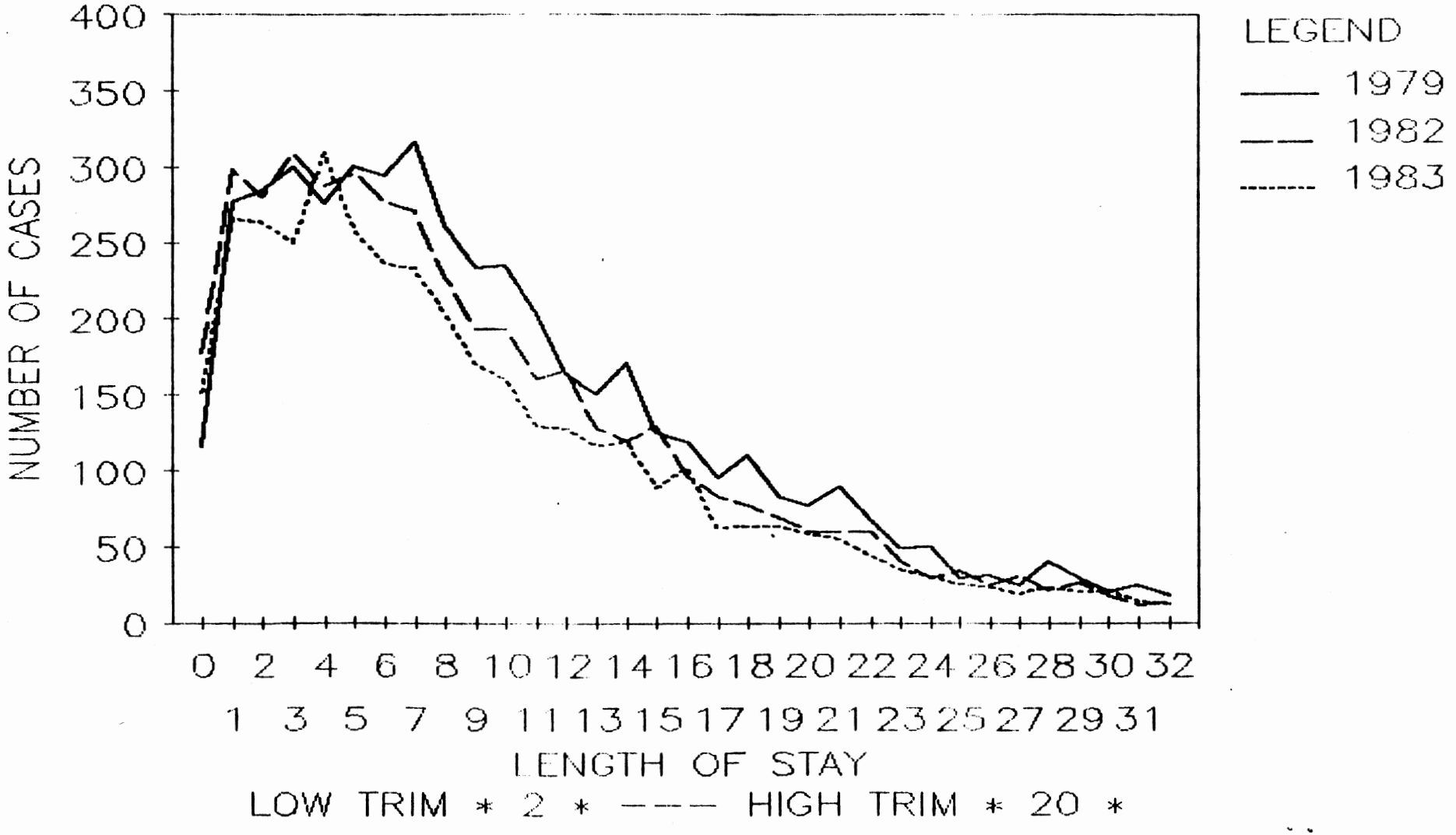
NJDOH

DRG 425
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



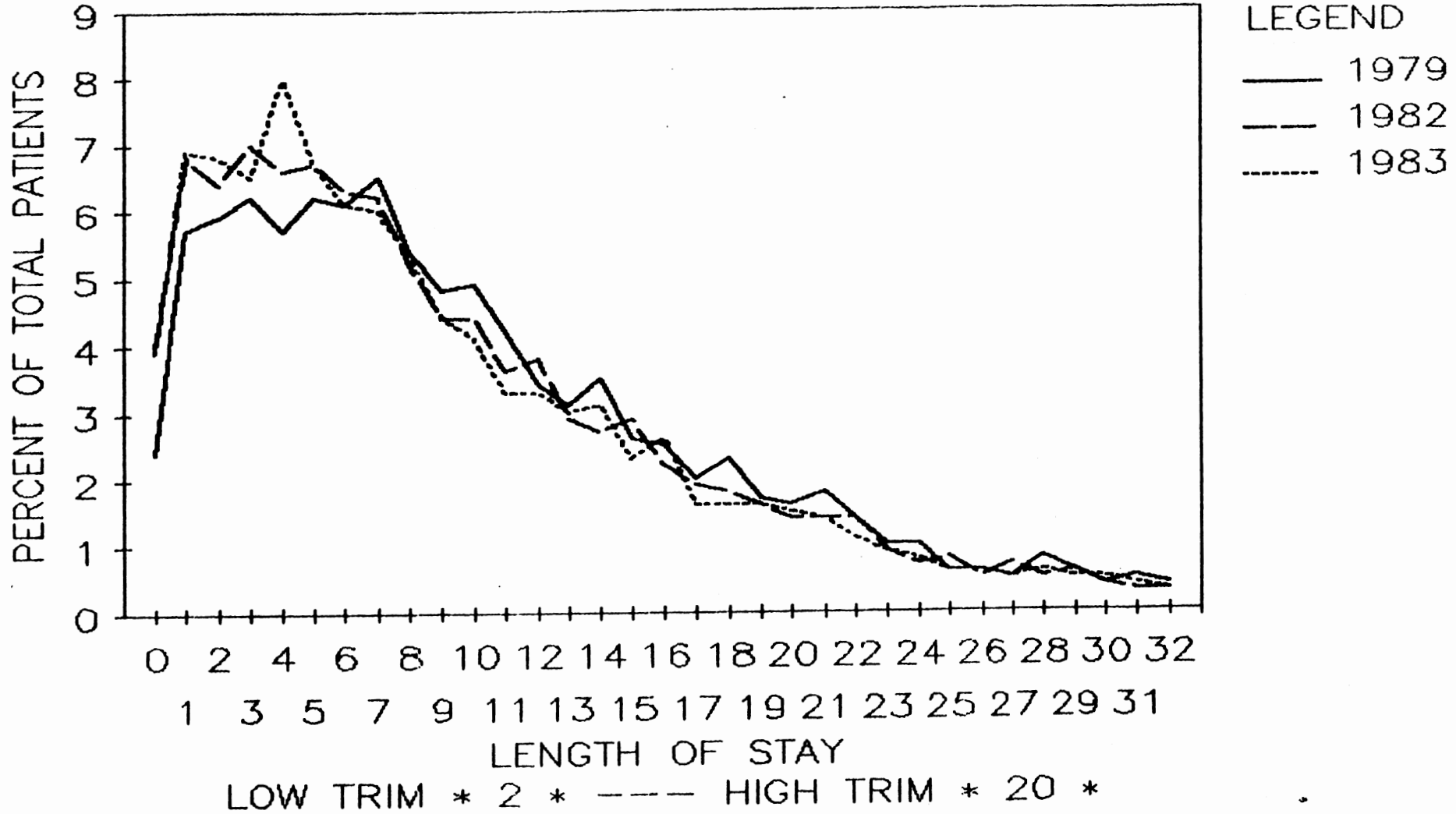
NJDOH

DRG 426
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



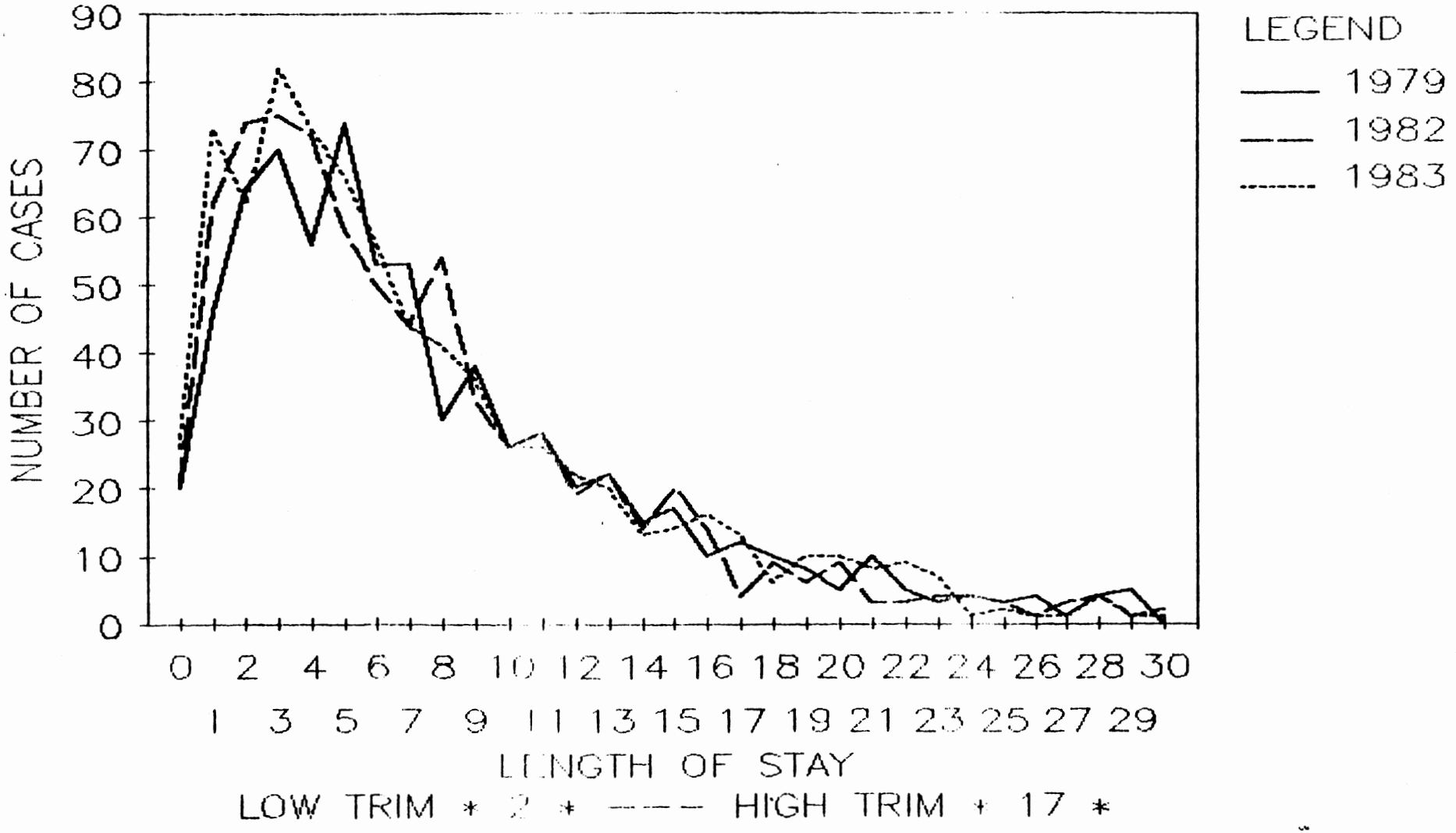
NJDOH

DRG 426
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



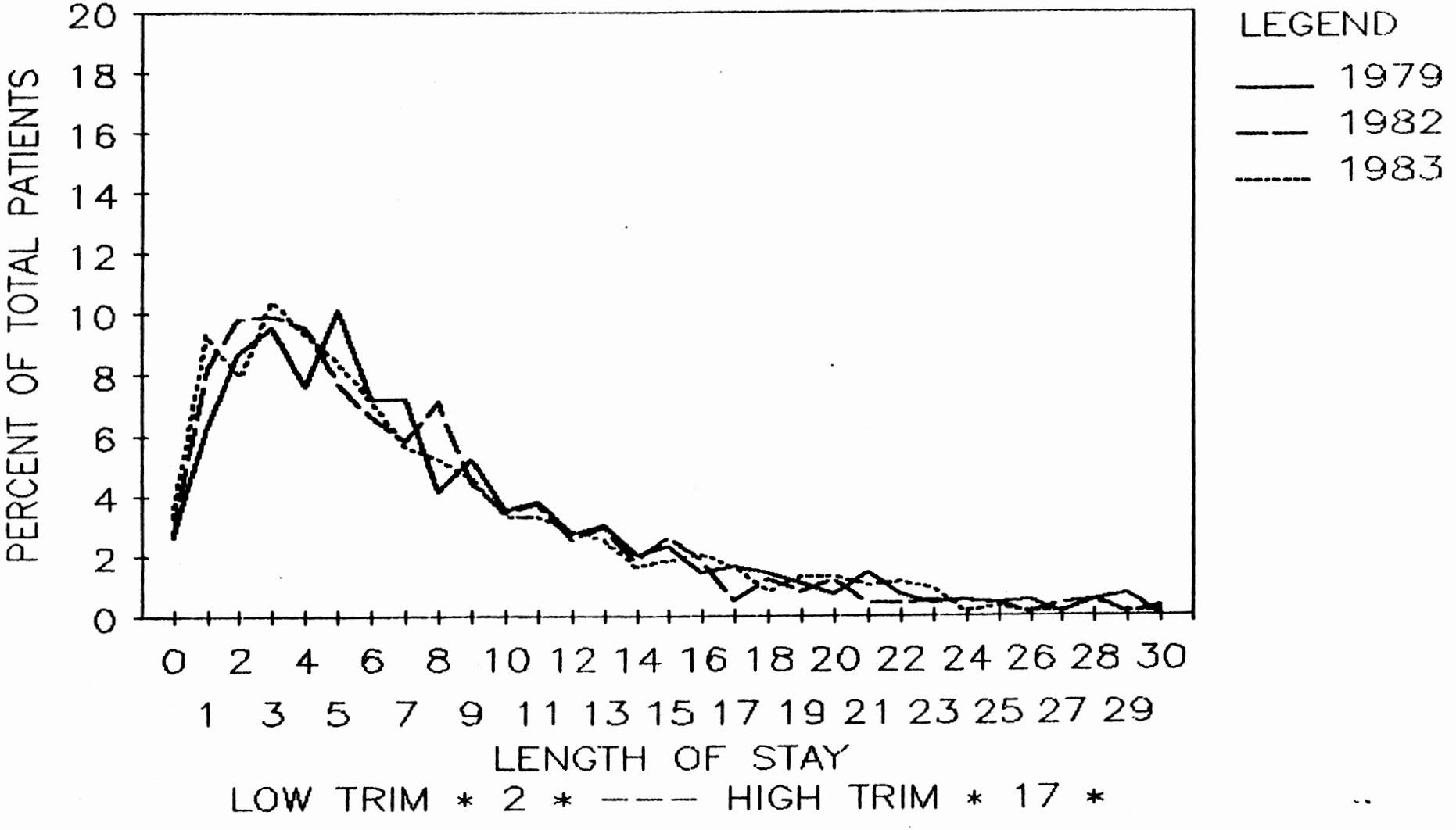
NJDOH

DRG 427
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



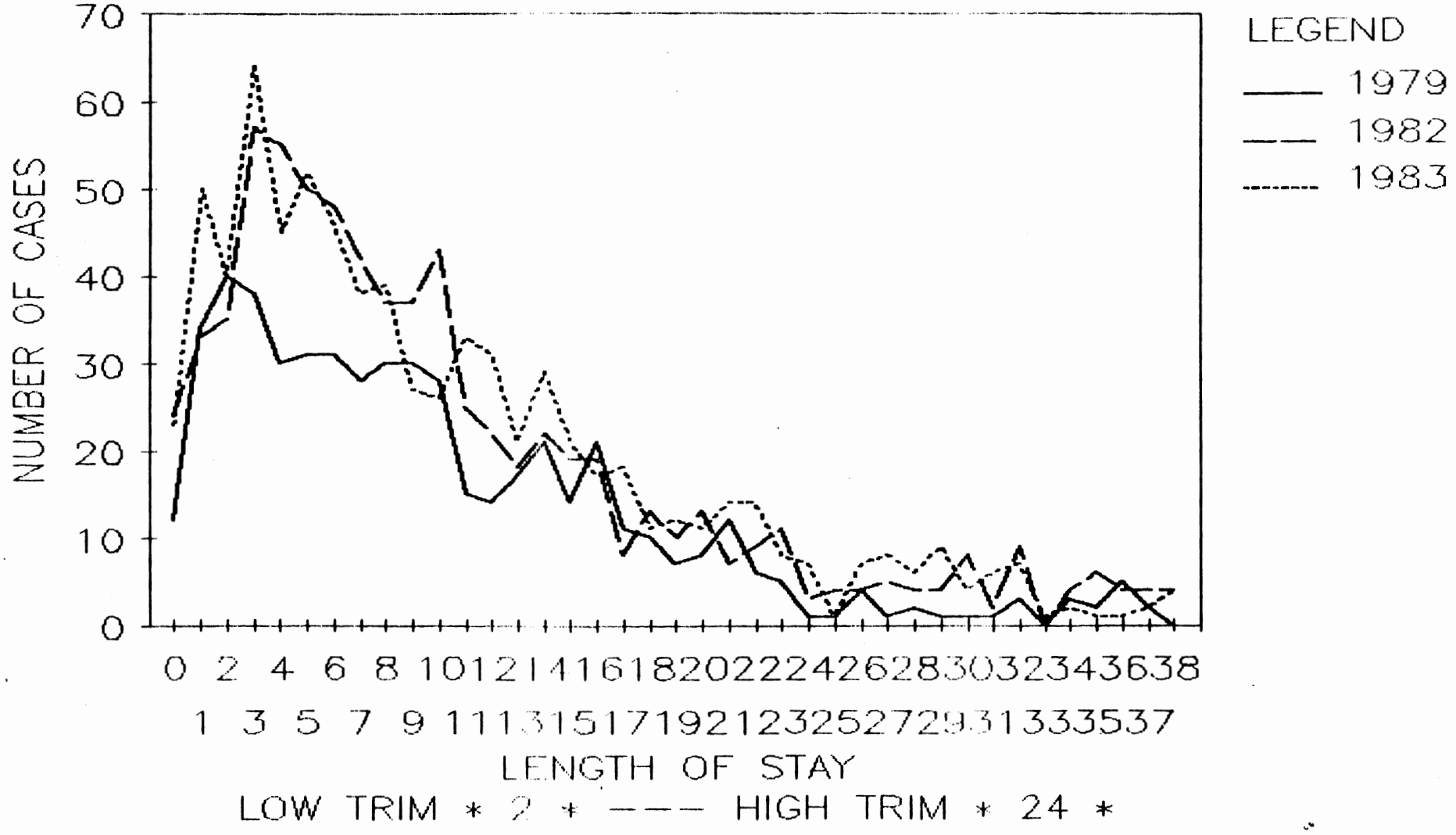
NJDOH

DRG 427
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



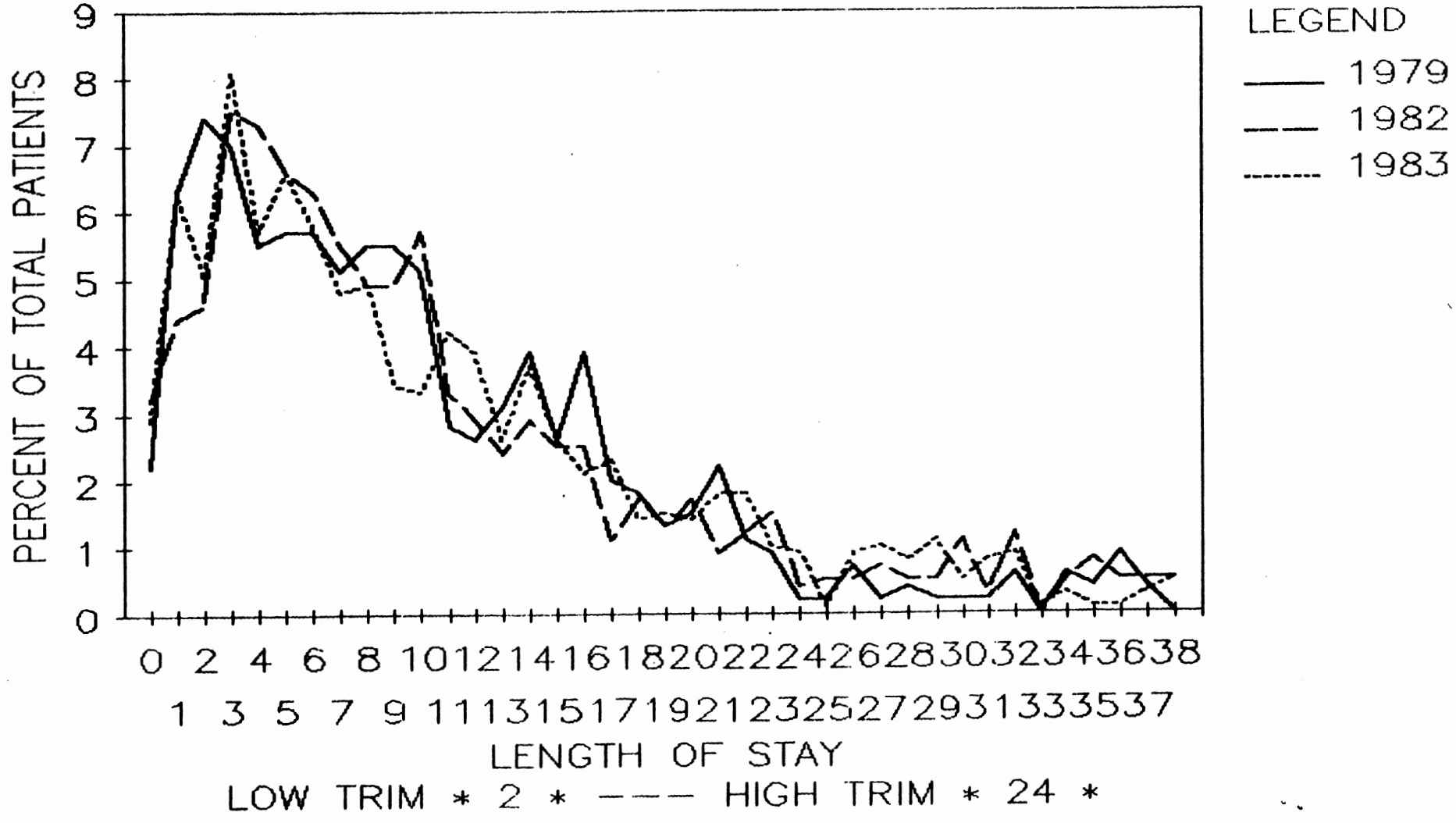
NJDOH

DRG 428
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



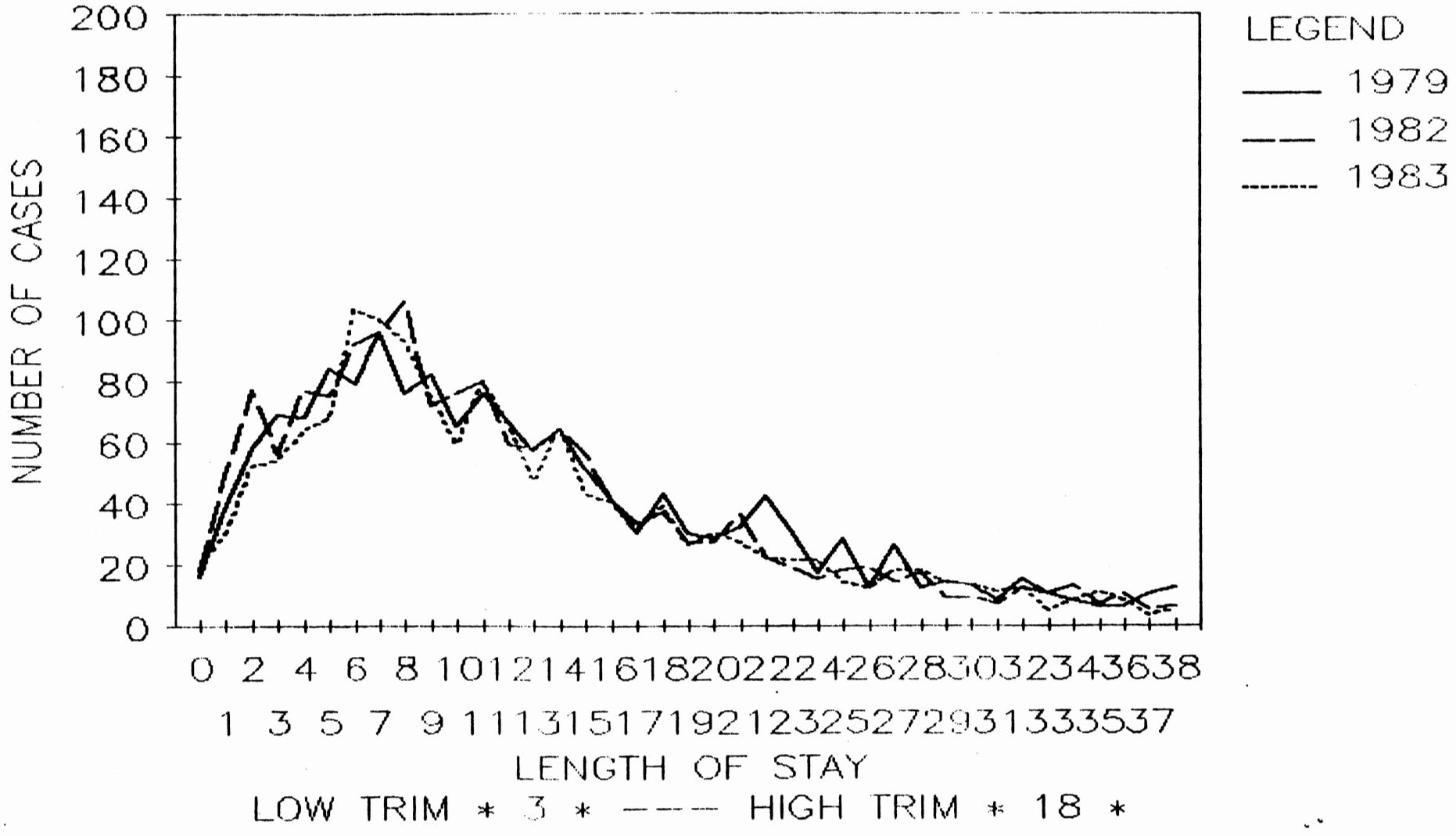
NJDOH

DRG 428
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



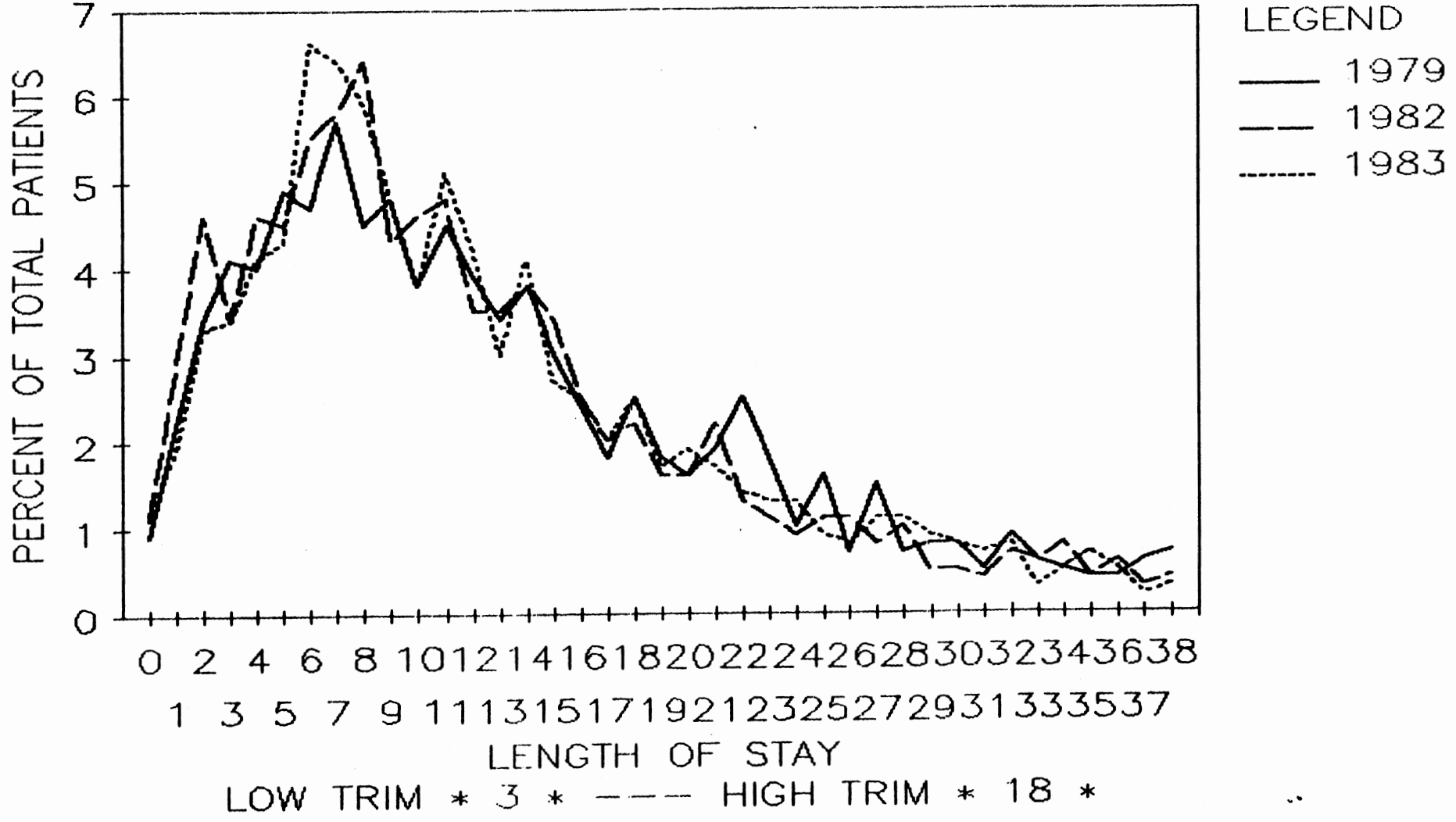
NJDOH

DRG 429
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



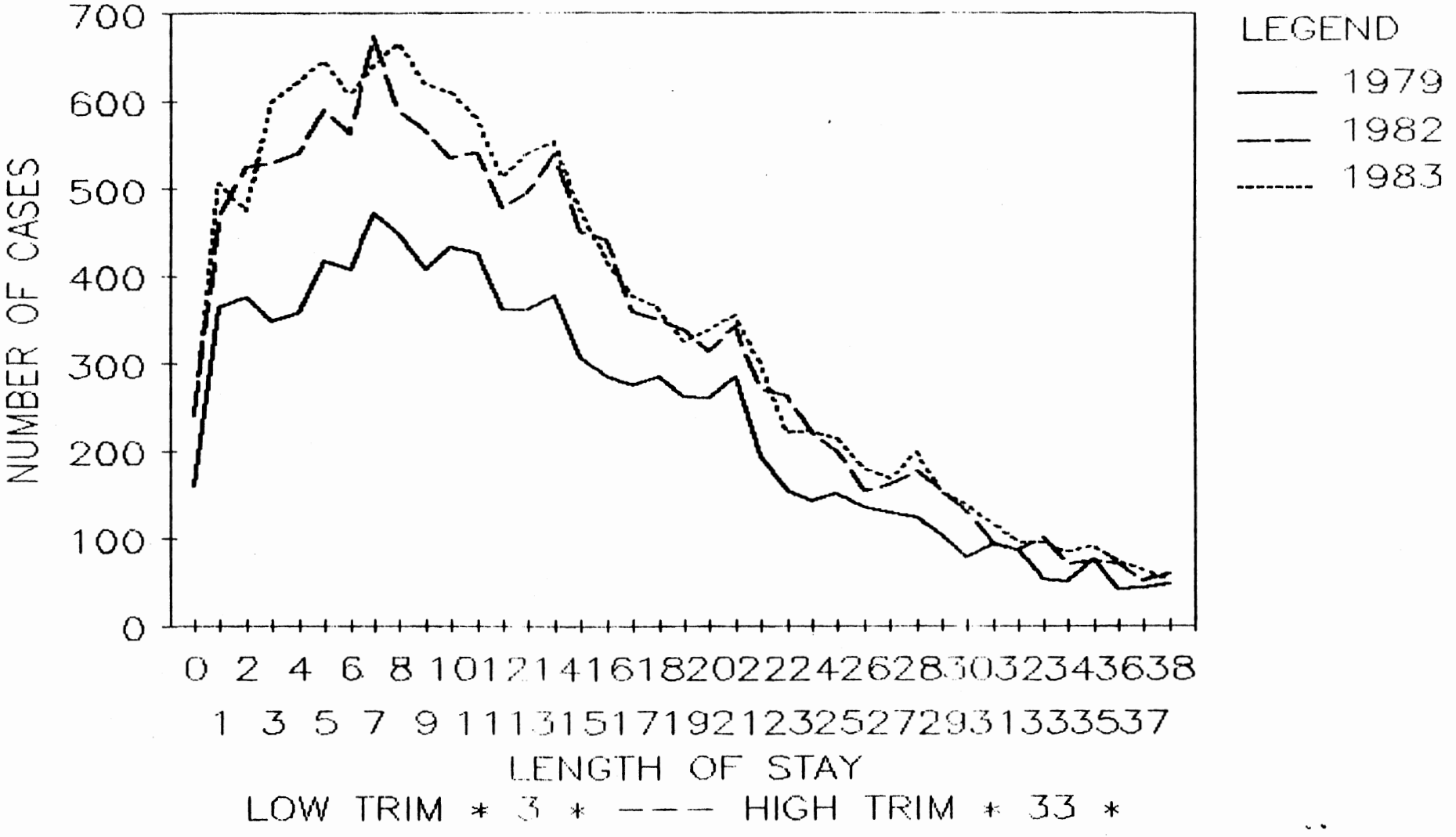
NJDOH

DRG 429
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



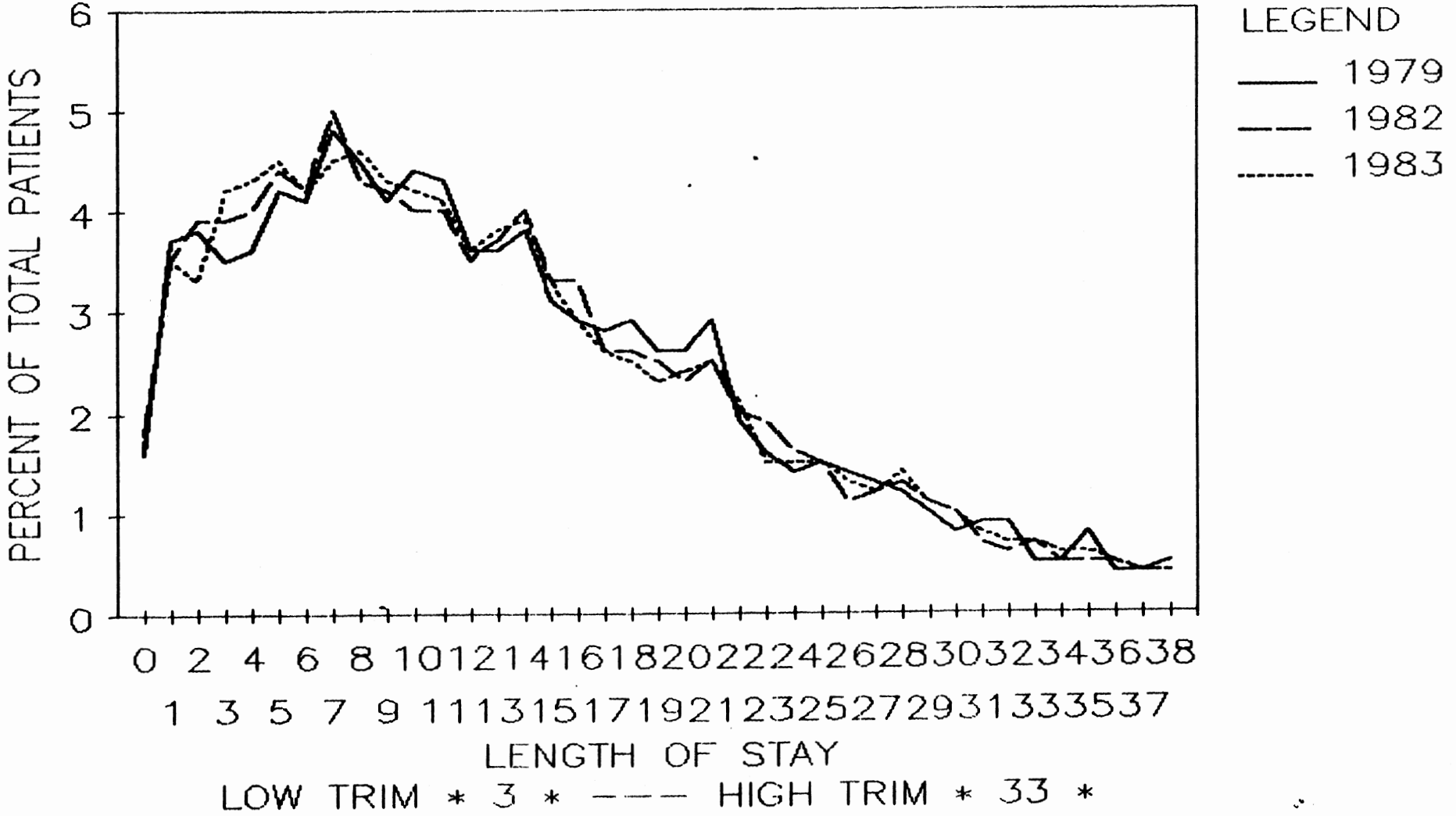
NJDOH

DRG 430
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



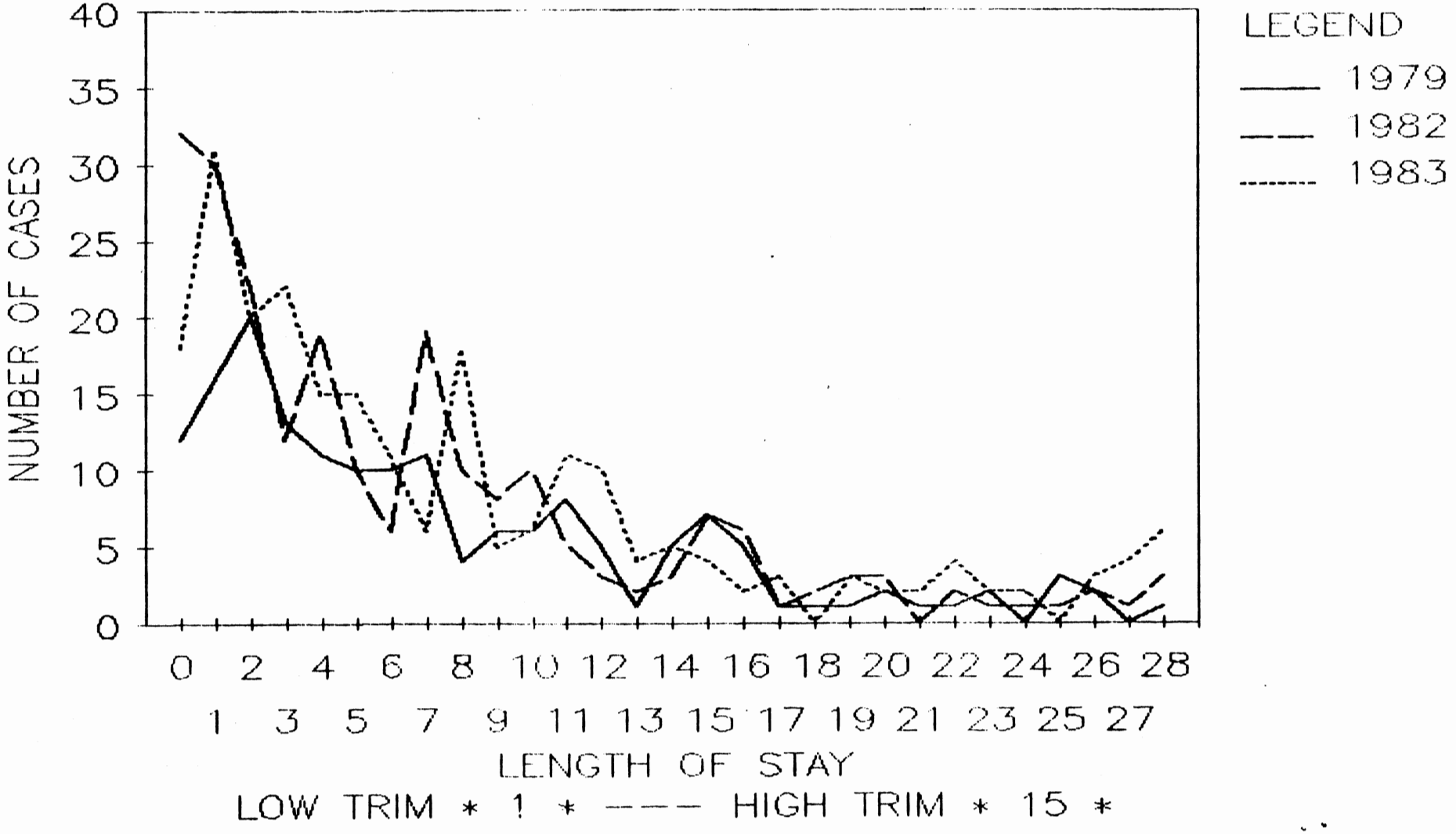
NJDOH

DRG 430
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



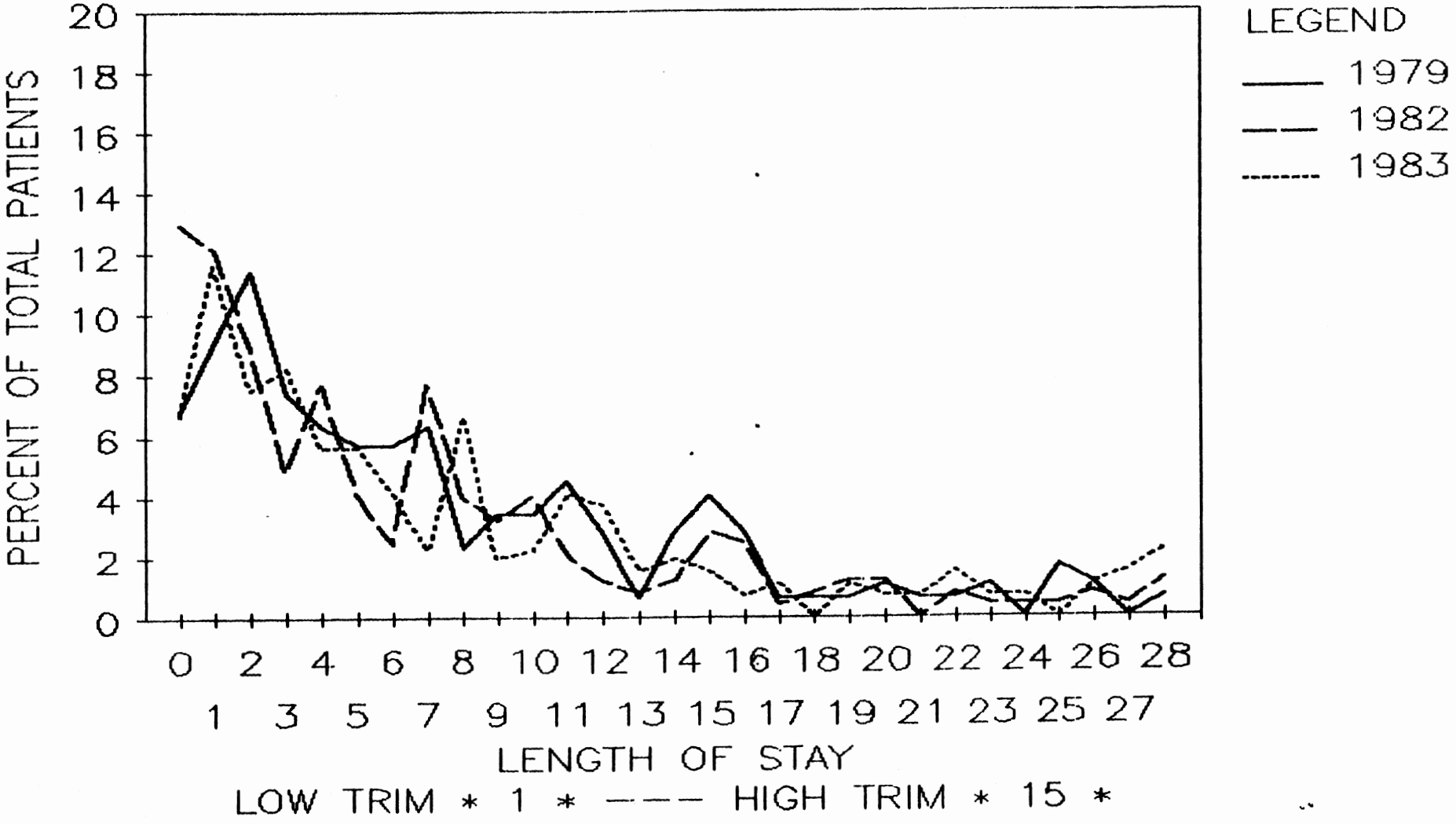
NJDOH

DRG 431
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



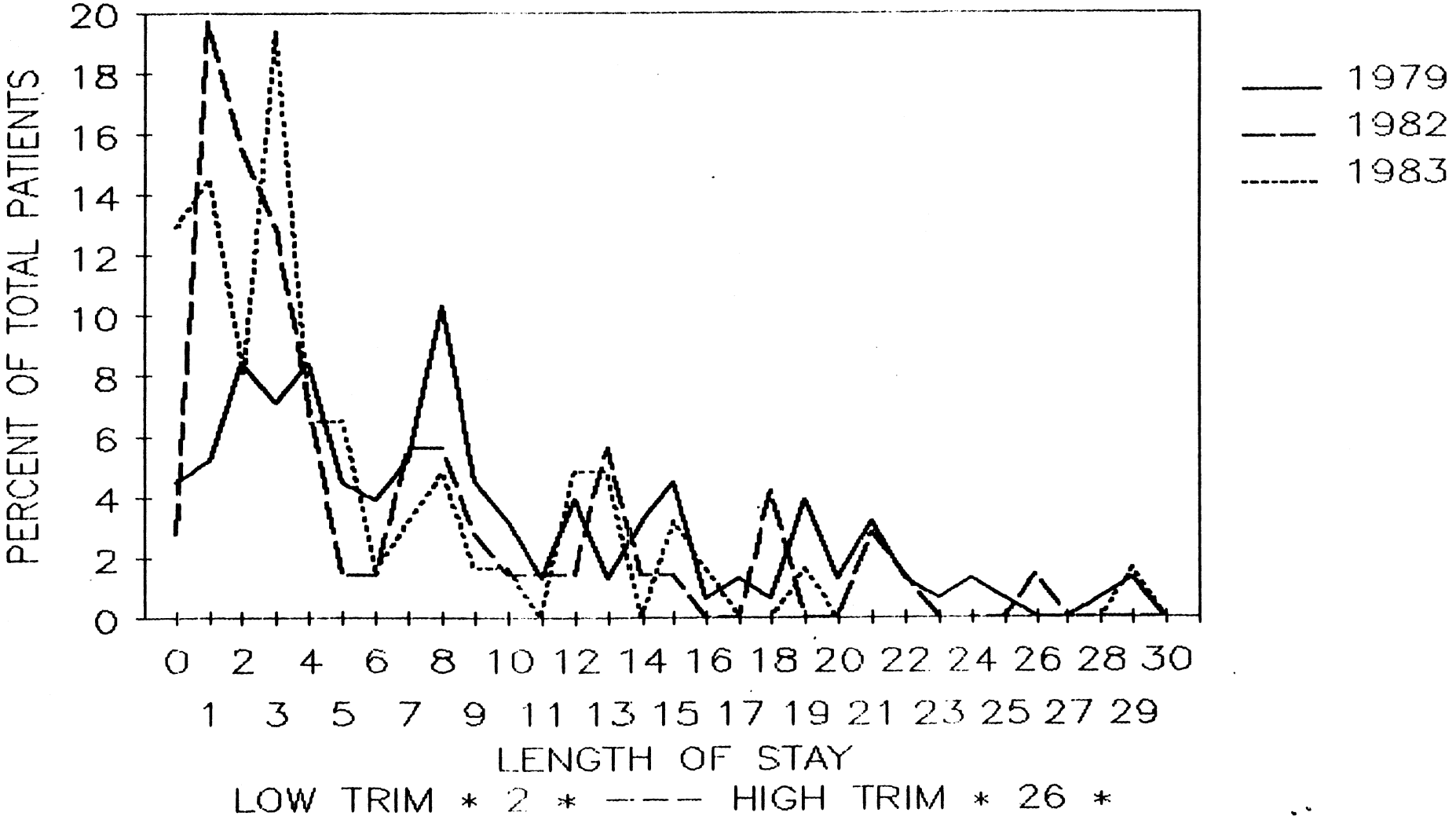
NJDOH

DRG 431
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



NJDOH

DRG 432
PATIENTS BY LOS
— UNTRIMMED / STATEWIDE —
1979 — 1982 — 1983



NJDOH

TESTIMONY FOR 6/5/85 PSYCHIATRIC DIAGNOSTIC RELATED GROUPS (DRG'S)

INTRODUCTION

GOOD AFTERNOON. I AM DENNIS LAFER, DEPUTY DIRECTOR OF THE DIVISION OF MENTAL HEALTH AND HOSPITALS. I APPRECIATE THE OPPORTUNITY TO PRESENT THE DIVISION'S OBSERVATIONS AND RECOMMENDATIONS PERTAINING TO THE DRG SYSTEM FOR PSYCHIATRIC REIMBURSEMENT IN NEW JERSEY.

I. OVERVIEW

FIRST LET ME SAY, IN GENERAL, OUR EXPERIENCE WITH THE DRG SYSTEM, HAS BEEN VERY POSITIVE. THE SYSTEM'S INCLUSION OF PROVISIONS TO ADDRESS BAD DEBT AND UNCOMPENSATED CARE, WHICH INCIDENTALLY DISTINQUISHES NEW JERSEY'S SYSTEM FROM MOST OF THE OTHER STATES IN OUR COUNTRY, THE FLEXIBLE RECOGNITION OF OUTLIERS OR CASES IN WHICH COMPLICATING FACTORS ARE PRESENT, AND THE ALL PAYOR PROVISION, ARE FEATURES OF THE NJ SYSTEM WHICH FACILITATE THE

ABILITY OF LOCAL GENERAL HOSPITALS TO PROVIDE ACUTE CARE TO ALL PEOPLE OF THE STATE WHO REQUIRE THIS LEVEL OF CARE. THE DIVISION OF MENTAL HEALTH AND HOSPITALS' GOAL IN THIS REGARD, IS TO ENSURE THAT MENTALLY ILL PERSONS HAVE THE OPPORTUNITY TO RECEIVE ACUTE CARE TREATMENT WITHIN THEIR LOCAL COMMUNITY, CLOSE TO FAMILIES AND RELATIVES. OUR EXPERIENCE HAS BEEN THAT TREATING AND CARING FOR SOMEONE IN THEIR COMMUNITY, WHICH MAY INVOLVE AN INPATIENT STAY IN A LOCAL HOSPITAL, IS THE MOST EFFECTIVE WAY TO FACILITATE AN IMPROVEMENT IN A PERSON'S FUNCTIONING AND ADDRESS THE FACTORS WHICH PROVOKED THE ACUTE CARE EPISODE.

II. INADEQUACY OF PSYCH DRG'S

WHILE WE HAVE MUCH TO BE PROUD OF IN NEW JERSEY WITH RESPECT TO OUR REIMBURSEMENT SYSTEM FOR GENERAL INPATIENT CARE, THE AREA OF DRG'S FOR PSYCHIATRIC CARE PRESENT A RANGE OF PROBLEMS THAT WE NEED TO ADDRESS. IT IS UNDERSTANDABLE THAT SINCE PSYCHIATRIC

COSTS, COMPARED TO HEALTH CARE COSTS, REPRESENTS ONLY 2%, THAT THIS AREA HAS NOT RECEIVED THE MUCH NEEDED ATTENTION WHICH IT DESERVES, GIVEN THE MANY PROBLEMS OF IMPLEMENTING THE ENTIRE SYSTEM. HOWEVER, WE FEEL THAT THE SYSTEM HAS DEVELOPED OVER THE LAST 7 OR 8 YEARS TO A POINT SO THAT IT IS NOW IMPERATIVE THAT WE ADDRESS THE ISSUES SURROUNDING THE PSYCHIATRIC DRG'S. WE COMMEND THE COMMITTEE CHAIRMAN AND THE MEMBERS OF THE COMMITTEE SPONSORING THIS HEARING.

THE MAJOR PROBLEMS ASSOCIATED WITH THE CURRENT PSYCHIATRIC DRG'S ARE THREEFOLD.

FIRST, DIAGNOSIS, WHICH IS WHAT THE NJ DRG'S ARE BASED UPON, ARE POOR PREDICTORS OF LENGTH OF STAY IN PSYCHIATRY. THIS FUNDAMENTAL PROBLEM, THE INADEQUACY OF THE DIAGNOSTIC SYSTEM, TO PREDICT LENGTH OF STAY (LOS), CALLS INTO QUESTION THE ENTIRE VALIDITY OF TRYING TO ESTABLISH RATES BASED UPON PSYCHIATRIC DIAGNOSIS.

SECOND, BECAUSE OF THE INABILITY TO LINK DIAGNOSIS WITH LENGTH OF STAY, AN INACCURATE ASSESSMENT OF RESOURCE CONSUMPTION, OR THE AMOUNT OF TREATMENT AND CARE PROVIDED TO PSYCHIATRIC PATIENTS, OCCURS.

THIRD, AND FINALLY, THE REIMBURSEMENT LEVEL DOES NOT ADEQUATELY MATCH EXPENDITURES FOR THIS CARE. THUS, DISINCENTIVES EXIST FOR HOSPITALS TO CARE FOR PSYCHIATRIC PATIENTS WHO REQUIRE MORE INTENSIVE INTERVENTION AND TREATMENT.

IN MENTAL HEALTH REIMBURSEMENT, WE NEED TO FOCUS UPON THE DEGREE OF SEVERITY OF ILLNESS RATHER THAN DIAGNOSIS. THIS VARIABLE IS LIKELY TO HAVE GREATER IMPACT ON DEVIATION OF TREATMENT THAN IN PHYSICAL MEDICINE. FOR PSYCHIATRIC PATIENTS, FACTORS OTHER THAN DIAGNOSIS, SUCH AS LEVEL OF FUNCTIONING, HISTORY OF ILLNESS, AVAILABILITY OF AFTERCARE, AVAILABILITY OF

SOCIAL SUPPORT FOR POST HOSPITALIZATION PLACEMENT, CAN BE EXPECTED TO SIGNIFICANTLY IMPACT THE LENGTH OF STAY.

AVAILABLE STATISTICAL DATA SUPPORTS OUR OBSERVATIONS THAT PSYCHIATRIC DIAGNOSIS IS A POOR PREDICTOR OF LENGTH OF STAY. ONE WOULD EXPECT, IF THE PSYCHIATRIC DRG GROUPINGS WERE GOOD PREDICTORS OF LENGTH OF STAY (LOS), OR THAT THE TIME SPENT IN GENERAL HOSPITALS, WITH DESIGNATED PSYCHIATRIC UNITS, WOULD CLUSTER AROUND AVERAGE NUMBER OF DAYS. ACTUALLY, WE HAVE FOUND THAT THE AVERAGE LOS FOR PSYCHIATRIC PATIENTS IN 40 GENERAL HOSPITAL PSYCHIATRIC UNITS RANGES FROM **8.8** DAYS TO **24.3** DAYS, DESPITE SIMILAR CASE MIX.

NEW JERSEY IS NOT ALONE IN RECOGNIZING THE INADEQUACY OF THE PSYCHIATRIC DRG'S TO PREDICT THE DURATION OF TREATMENT IN A PSYCHIATRIC UNIT. **NATIONALLY,** CONGRESS ACKNOWLEGED THIS DIFFICULTY BY EXCLUDING PRIVATE PSYCHIATRIC HOSPITALS AND

DESIGNATED UNITS WITHIN A GENERAL HOSPITAL FROM THE NATIONAL PROGRAM, UNTIL FURTHER STUDY AND RECOMMENDATIONS COULD BE MADE.

WE HAVE BEEN ACTIVELY INVOLVED WITH TWO NATIONAL EFFORTS TO EXAMINE THE PROBLEMS ASSOCIATED WITH PSYCHIATRIC DRG'S. CURRENTLY, THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS IS STUDYING DATA OF 300,000 DISCHARGES FROM PRIVATE PSYCHIATRIC HOSPITALS. THEIR ANALYSIS IS DIRECTED TOWARD TESTING THE FEASIBILITY OF SEVERAL PROSPECTIVE PAYMENT METHODS OTHER THAN DRG'S.

THE AMERICAN PSYCHIATRIC ASSOCIATION IS PERFORMING TWO TYPES OF ANALYSIS ON PSYCHIATRIC DRG'S. THE APA ESTABLISHED A CLINICAL TASK FORCE TO REVIEW THE DRG CLASSIFICATION AND A SECOND TASK FORCE UNDER THEIR COMMITTEE ON FINANCE TO ANALYZE DATA ON APPROXIMATELY ONE MILLION DISCHARGES.

III. SUMMARY

IN SUMMARY, I HAVE POINTED OUT THAT THE CURRENT DRG GROUPING FOR PSYCHIATRIC PATIENTS ARE INADEQUATE. THE RELIANCE OF THESE DRG'S ON DIAGNOSIS HAS SHOWN A LIMITED ABILITY TO PREDICT LENGTH OF STAY IN OUR GENERAL HOSPITAL PSYCHIATRIC UNITS. THE PROBLEMS ASSOCIATED WITH PSYCHIATRIC DIAGNOSIS HAVE BEEN RECOGNIZED BY APA AND OTHER NATIONAL GROUPS.

ON A NATIONAL LEVEL, CONGRESS HAS ACKNOWLEDGED THE INADEQUACY OF PSYCHIATRIC DRG'S BY EXEMPTING UNTIL DECEMBER 1985 PRIVATE PSYCHIATRIC HOSPITAL AND DESIGNTED UNITS IN GENERAL HOSPITALS PENDING THE OUTCOME OF THESE TWO MAJOR STUDIES.

I HAVE FURTHER ADDED THAT THE INADEQUACY OF THE PSYCHIATRIC DRG'S RESULTS IN A LIMITED RECOGNITION OF THE RESOURCE CONSUMPTION BY PSYCHIATRIC PATIENTS IN THESE SETTINGS. CONSEQUENTLY, UNDER THE CURRENT SYSTEM, ADEQUATE REIMBURSEMENT TO GENERAL HOSPITALS CANNOT BE PREDICTED BY THESE FACILITIES IN MEETING THE COMPLEX TREATMENT NEEDS OF PSYCHIATRIC PATIENTS.

IV. RECOMMENDATIONS

CONSEQUENTLY, I SUBMIT FOR CONSIDERATION THE FOLLOWING RECOMMENDATIONS:

1. REVISE THE PSYCHIATRIC DRG'S TO MORE ADEQUATELY REFLECT PATIENT TREATMENT NEEDS.

FIRST, THESE REVISIONS IN PART, WOULD BE BASED UPON THE WORK OF THE MAJOR NATIONAL STUDIES CURRENTLY BEING CONDUCTED. SECONDLY, THESE REVISIONS WOULD BE BASED UPON PROGRAM STANDARDS GOVERNING THE OPERATION OF PSYCHIATRIC UNITS IN WHICH WOULD BE DEVELOPED BY DHS/DMH&H AND DOH WITH SUBSTANTIAL INPUT FROM THE NJ HOSPITAL ASSOCIATION.

2. REVISE THE REIMBURSEMENT RATES TO BETTER REFLECT RESOURCE CONSUMPTION

BETTER PREDICTION OF LENGTH OF STAY BASED UPON TREATMENT NEEDS AND THE MULTIDIMENSIONAL ASSESSMENT OF PATIENT CONDITION SHOULD DRIVE THE DEVELOPMENT OF PROGRAM STANDARDS. THESE STANDARDS WOULD MORE ADEQUATELY REFLECT THE RESOURCES NEEDED TO PROVIDE A QUALITY CARE TO PSYCHIATRIC PATIENTS IN THESE SETTINGS WHICH ARE CLOSE TO WHERE THEY LIVE.

APPROPRIATE ADJUSTMENTS TO THE REIMBURSEMENT STRUCTURE MUST FOLLOW THE IDENTIFICATION OF MORE APPROPRIATE DIAGNOSTIC AND RESOURCE ASSESSMENT STANDARDS.

3. INCLUDE REVISIONS TO MENTAL HEALTH CARE IN SYSTEMWIDE REVISIONS

WHILE I MENTIONED NUMEROUS REASONS WHY PSYCHIATRIC CARE DIFFERS FROM GENERAL/MEDICAL SURGICAL CARE, IT IS EXTREMELY IMPORTANT THAT ANY CHANGE TO OUR HEALTH CARE REIMBURSEMENT SYSTEM MUST INCLUDE PSYCHIATRIC CARE. HISTORICALLY, IT HAS BEEN DEMONSTRATED THAT WHEN MENTAL HEALTH CARE IS SEPARATE, PSYCHIATRIC SERVICES ARE AT RISK OF NOT ONLY INADEQUATE FUNDING, BUT THE TOTAL LACK OF FUNDING.

DL/JL/DAB

6/3/85

MARK F. CETTA, PH.D.
1 Mayforth Terrace
Demarest, New Jersey 07627
201-784-0824

June 5, 1984

STATE OF NEW JERSEY
ASSEMBLY
Committee On Corrections, Health and Human Services
CN 042
State House Annex
Trenton, New Jersey 08625

Honorable Sirs:

The following testimony is offered on behalf of the New Jersey Association For The Advancement Of Psychology. I urge you to take it into account as you assess the impact of the Diagnosis Related Group (DRG) System on short term psychiatric care in New Jersey

I wish to make two points.

Firstly 'psychiatric' care is a misnomer. Modern mental health care is a team effort. It is mandated to be so by the Joint Committee on Accreditation of Hospitals. Many people from many professional disciplines take part including psychologists, psychiatrists, nurses, social workers, and vocational counselors. You must take into account that Mental health treatment is 'people intensive' as you examine a system of reimbursement.

Secondly, mental health treatment is in a period of transition. Different professional groups are struggling fiercely for a share of the marketplace. By and large, this is a positive trend. It has lead to better services which are more widely available at a lower to cost to the public. Until relatively recently hospitals were very little effected by this competition. Now several key decisions by the Joint Commission

on the Accreditation of Hospitals have reversed this trend, and more and more psychologists have begun to practice independently in hospitals. Care must be taken in your deliberations, for a decision simply for the status quo could enshrine an old and anachronistic system of care at the expense of the sort of competition which leads innovative change.

Respectfully submitted;

Mark F. Cetta, Ph.D.