

Verification of DRG hospital invoices by health insurers Appraisal of the changeover period prior to the new hospital financing

Key facts

SwissDRG (Swiss Diagnosis Related Groups) is the new tariff system for in-patient acute somatic⁴ hospital services. Invoicing in accordance with the SwissDRG flat-rate payment system has been used since 2012. From 2014, health insurers must have a data collection point certified by the Federal Data Protection and Information Commissioner (FDPIC) for processing medical bill information. It is basically too soon for an extensive analysis of SwissDRG invoice verification by the health insurers since no solid experience data is available. In spite of this, the Swiss Federal Audit Office (SFAO) has taken the decision to conduct an analysis within the current changeover period. The aim is to give a transparent picture of the current situation and point to any problems or critical areas so that possible improvements can be made at an early stage.

The consequences and impact of the new hospital financing are being analysed by the Federal Office of Public Health (FOPH) within the scope of the evaluation of the Health Insurance Act revision of hospital financing by means of scientific studies in six topic areas up to 2018.

The SwissDRG tariff system is still in the introductory phase

Based on the Health Insurance Act, in-patient hospital services have been financed since 1 January 2012 according to uniform criteria throughout Switzerland. The diagnoses and medical procedures carried out on the patient are recorded with the new SwissDRG tariff system and are allocated to a so-called case group and are reimbursed at a flat rate. Each diagnosis is assigned a severity level. An appendectomy with no complications has a much lower severity level for example than a heart operation. Hospital services are no longer paid on the basis of the duration of the stay in hospital but on the basis of the treatment case. Overall the costs for the annual 1.3 million in-patient hospital stays are approximately CHF 12 billion, which is approximately half of the overall hospital costs in Switzerland.

The new tariff system is meant to improve transparency of services and prices of hospital treatments as well as the comparability throughout Switzerland. This should promote competition between hospitals and finally reduce the costs of hospital treatments overall.

New challenges for health insurers in the examination of DRG invoices

The new type of compensation for in-patient hospital services is connected with new challenges for health insurers, such as regulating which data how and in which form would have to be made available to them in view of the financial and performance audits. The invoices now also contain medical information in addition to administrative data. In concrete terms, this means that the health insurer receives a so-called minimum clinical dataset (MCD) with every DRG invoice, containing the diagnoses and medical procedures on the insured persons. To maintain data protection and ensure the proportionality of invoice verification, the insurers had to set up a data collection point. This collection point precedes the insurer and has the task of automatically identifying ("intercept-

⁴ The term "acute care" is understood to mean in-patient care of acute illnesses or accidents. "Acute care" does not cover mental illness and measures to do with medical rehabilitative care.



ing") any conspicuous DRG invoices. In concrete terms, this means that checking the content of DRG invoices requires special medical expertise. For this, the health insurers require specialists with coding experience or medical knowledge.

On average high coding quality of DRG invoices and so far only few invoice corrections

As the coding of a case of treatment based on the medical documents constitutes the basis for invoicing, ensuring the accuracy of the coding is vital. The correctness of a DRG invoice is ensured in the hospitals by means of various measures. These activities include the coding of the DRG invoices by specially trained medical staff, internal quality controls, organisational separation of medical treatment, coding and DRG invoicing. Moreover, the quality of the coding in the hospitals is assessed annually by means of a selection of random samples by external auditors using subsequent coding.

The quality of the coding is considered by the interviewed players (insurers, hospitals and cantons) to be good to very good. On the basis of the invoice verifications by the health insurers, up to now about 0.5% of the DRG invoices were either recoded or corrected, in favour of or to the disadvantage of the hospital. However, it should be noted that what we are dealing with here are initial empirical values and assessments as the electronic verification system with data collection points has not yet been fully implemented by the health insurers. A full overview of the results of the coding revisions or of the SwissDRG invoice verification by the health insurers is not available today. It is thus too early to judge to what extent the low number of DRG corrections is due to the good quality of the DRG invoices or whether the current verification processes have not yet been optimised.

The coding revisions in the hospitals and the verifications by the health insurers are complementary

The coding revision in the hospitals is based on random sampling, i.e. a non-suspicion-based selection of DRG invoices and allows a purely statistical and quantitative observation of the general coding quality. It cannot replace the administrative individual case verifications or the supplementary, targeted and risk-based verifications concentrating on conspicuous invoices carried out by the health insurers. The coding revisions in the hospitals and the verifications by the health insurers should be seen as complementary activities.

Currently health insurers have little experience with DRG invoice verifications

In total the health insurers process and verify approximately 90 million invoices p.a. The number of DRG invoices at approximately 1.3 Mio. annual in-patient stays (1.5% of all invoices) is relatively small. However, the average invoice amounts are relatively high (average 4300 versus 300 CHF). The health insurers conduct a standardised "actuarial" basic verification of all SwissDRG invoices. Moreover, it is now possible to conduct verification of the content on the basis of the medical dataset. The aim is to use IT-based systems to determine the correctness of the services charged, to conduct additional investigations in the case of conspicuous findings and if need be, to request further documents from the hospitals.

Up to now, little use has been made of the possibility of automated identification ("interception") of conspicuous DRG invoices. The health insurers thus have only non-standardised and patchy expe-

rience of substantive DRG invoice verifications. This is because at the start of introduction in 2012, the legal and technical framework for electronic transmission of the invoice data was not yet in place.

Usefulness and effectiveness of automated invoice verification cannot yet be assessed

The initial results from invoice verifications indicate that the test procedure on the basis of manually identified invoices is inefficient for further clarification. Efficient, substantive invoice verification is only possible if the data is available electronically and can be selected for further clarification on an automated and risk-based basis using specific criteria. Since the start of 2014, the foundations for this have been laid with the setting up of the data collection points. With the exception of three small health insurers, all insurers had an office of this nature by autumn 2014. Before the usefulness and effectiveness of the automated and selected invoice verification can be assessed by the health insurers, several years of experience are needed. The SFAO has notice of a case where an agreement between a hospital and a health insurer has been signed according to which minor discounts are granted when a certain given request rate is not exceeded. The SFAO cannot estimate to what extent such agreements between hospitals and health insurers are being applied in Switzerland.

The interests of the hospitals as service providers on the one hand and the health insurers on the other are not the same. There is a certain amount of competition, e.g. concerning the coding specialists sought in the labour market. In order to avoid the unnecessary administrative burden in the case of verifications, clarifications and requests on both sides, an improvement in the trust relationship needs to be built up by means of mutual and transparent communication

Moreover, the question arises as to whether an independent arbitration body could be of use to efficiently settle inconsistencies relating to coding between the hospitals and the health insurers.

No disproportionate duplication between the verification activities of the health insurers and the cantons

In the case of the new hospital financing, the cantons will contribute to the in-patient services in all public and private hospitals in accordance with the list of hospitals at the latest from 2017 with a 55% share of the costs. The cantons will thereby receive their proportionate bills from the hospitals albeit mostly in aggregate form per hospital and without the medical dataset.

The division of labour between the cantons and health insurers in the SwissDRG invoicing process was in principle regulated so that financial audits and performance audits are conducted by the health insurers and the cantons relinquished the parallel development of a similar audit structure. In contrast to the health insurers, the cantons have no access to the medical dataset. The cantons are the biggest purchaser of hospital services and it is therefore understandable that they want to at least verify their invoicing in accordance with administrative criteria (amongst other things, place of residence of the patient, intra-cantonal or extra-cantonal hospital treatment, guarantee of payment, etc.). The legislator has envisaged a dual financing system for in-patient hospital stays, it is thus understandable that insurances and cantons want to protect their financial interests. The SFAO has not detected any disproportionate duplication with the verification activities of the health insurers during the introduction of DRG.



According to the price control authorities, basic prices agreed between tariff partners are too high

The tariff partners (hospitals and insurers) set the level of the so-called basic price for each hospital. If no agreement can be reached, the canton sets the basic price. For the first two years of DRG in 2012 and 2013, negotiations between the contracting parties failed in many cases and as far as the price control authorities are concerned, the cantons have in part set the basic prices too high. In this regard, numerous appeals are pending before the Federal Administrative Court. The DRG invoices of the hospitals are thus often based on "provisionally" set basic prices. Since spring 2014, the first judgement on an appeal from health insurers against the tariff for in-patient treatment in the Lucerne Cantonal Hospital is available. In the judgement, neither the tariff set by the Cantonal Council of Lucerne (basic price CHF 10,325) was confirmed nor did the court follow the application of the 46 health insurers (basic price CHF 8,951). The basic price for the Lucerne Cantonal Hospital must now be renegotiated. For the 2014 fiscal year it has to be stated that the tariff partners have increasingly been able to come to an agreement and, in comparison to previous years, have tended to agree on lower basic prices.

Adjustments to the basic prices are, in comparison to the corrections to the DRG invoices up to now, of considerably greater financial relevance. Projected on the annual 1.3 million in-patient hospital stays, e.g. a change of CHF 100 in the basic price already amounts to CHF 130 million.

The recommendations to the Federal Office of Public Health (FOPH)

The SFAO recommendations concern initial optimisation measures within the scope of the current implementation of the Swiss DRG invoicing process:

- Designation of an arbitration body which in the event of disagreement in a SwissDRG case would make a conclusive assessment.
- Designation of an existing office which would ensure the complete and orderly implementation, evaluation and publication of coding revisions.
- In the event of corrections being made to invoices, ensuring that the hospitals will submit a report to the respective canton and health insurers.
- Clarification and specification of the criteria relating to effectiveness, functionality and efficiency and procedures for measuring and assessing in-patient hospital services.

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