



Weekly Checkup

Ten Costliest DRGs to Medicare and Beneficiaries

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The Centers for Medicare and Medicaid Services (CMS) recently released payment data for the 100 most commonly billed discharges by Diagnosis Related Group (DRG) at more than 3,000 hospitals using the Inpatient Prospective Payment System (IPPS) in 2013. These payments represent over 7 million discharges, or 60 percent of the total IPPS discharges billed to Medicare that year.^[1] The following chart shows the top 10 costliest DRGs to the Medicare system as a whole, counting payments by both the government (and/or supplemental private insurance) and beneficiaries (including copayments and deductibles). These 10 DRGs were responsible for nearly 1.7 million discharges with total payments per discharge averaging nearly \$23,000 for a total cost of more than \$26 billion. As illustrated, much of the cost is driven by the number of discharges—particularly for major joint replacement (DRG 470) and septicemia (DRG 871)—rather than the cost of the services. Percutaneous cardiovascular procedure (DRG 247) was the only DRG in this top 10 that was not also in the top 10 for number of discharges or average total payments per discharge.



[1] <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html>