Top 100 U.S. Orthopaedic Hospitals Demonstrate Inconsistent MS-DRG Price Transparency Reporting for Spinal Fusion

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INTRODUCTION:
The Medicare Severity-Diagnosis Related Group (MS-DRG) is a useful classification system for the Center for Medicare & Medicaid Services (CMS) to reimburse hospitals while also giving patients an estimate on their holistic hospital charges. Although MS-DRG data has become accessible in hospitals' Chargemaster data since the institution of the 2019 IPPS Hospital Price Transparency Final Rule, hospitals can also choose to report their standard charges using different coding systems such as Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or the hospital's own internal indicator. This heterogeneity in reporting can be confusing to patients. In this study, we examined how many hospitals use MS-DRG codes and if these codes reflect gross standard, only-insurance, or variable charges for spinal fusion (except cervical) procedures. This data can help amend future hospital price transparency policies to facilitate patient understanding of healthcare costs.

METHODS:
U.S. News & World Report 2021-2022 hospital rankings identified the top 100 orthopaedic departments/hospitals. MS-DRG codes included: 456 (spinal fusion except cervical with spinal curvature, malignancy, infection, or extensive fusions with major complication or comorbidity [MCC]), 457 (spinal fusion except cervical with spinal curvature, malignancy, infection, or extensive fusions with complication or comorbidity [CC]), and 458 (spinal fusion except cervical with spinal curvature, malignancy, infection, or extensive fusions without CC/MCC). Chargemasters were obtained and analyzed for presence of MS-DRG and charges. Data were further categorized as gross standard (GSC), insurance-only (IC), and variable (VC) charges.

RESULTS:
Among 100 hospitals evaluated, 98 (98%) hospitals had available chargemasters. Of those, 47 (48%) utilized MS-DRG. 30 (63.8%) hospitals had data for MS-DRG 456 with mean GSC $396,141.66 [$43,747.68 to $1,087,142.00]. 31 (66%) hospitals had data for MS-DRG 457 with mean GSC $250,036.02 [$41,202.57 to $650,327.00]. 30 (63.8%) hospitals had data for MS-DRG 458 with mean GSC $324,658.74 [$31,544.65 to $2,770,422.20]. Hospitals in the Southeast and Northeast regions had lower levels of overall MS-DRG compliance but similar intra-regional GSC, IC, and VC data.

DISCUSSION AND CONCLUSION:
The <50% hospitals that utilized the MS-DRG standard had inconsistencies in reported charge types. The lack of standard reporting procedures not only causes confusion, but also makes difficult the task of comparing costs between hospitals and limits the utility of published hospital pricing for patients. Further studies into charge-reporting standards are necessary to improve care transparency.