



T E N N E S S E E D E P A R T M E N T O F H E A L T H

TENNESSEE HOSPITAL CHARGE REPORTS 2009

Introduction

Hospitalizations are a major component in the cost of health care. Information on hospitalizations is important to researchers, analysts and to the public for making informed decisions about health care.

The Tennessee Department of Health, Division of Health Statistics has created this series of charge reports which examine the fifty (50) most costly diagnostic categories and compares them among hospitals. These reports are based on approximately 903,000 inpatient records.

The five most expensive APR-DRGs in terms of total charge to Tennesseans are in order: Knee Joint Replacement (DRG 302); Septicemia and Disseminated Infections (DRG 720); Dorsal and Lumbar Fusion Proc Except for Curvature of Back (DRG 304); Percutaneous Cardiovascular Procedures w/o AMI (DRG 175); and Other Pneumonia (DRG 139). The high total charge for these procedures reflects both the cost of an individual procedure and the number of procedures performed.

Description of the Charge Report

The reports give data for patients discharged in 2009. The charge listed in the reports is the base charge for a hospitalization. It is not necessarily the actual charge made to the patient or his insurer. Nevertheless, the hospital's base charge is useful for comparison and is the only generally available figure for making case by case comparisons.

The inpatient discharge records are analyzed based on primary diagnosis, other diagnoses and on procedures used in patient treatment. The records are then assigned to diagnostic categories by use of All Patient Refined-Diagnosis Related Groups or APR-DRG*.

Next, the records are assigned to one of four severity groups for which similar types and amounts of treatment are needed. This allows for better comparisons of similar cases in terms of cost. In addition, because hospitals differ by the proportion of difficult and complex cases they see, the severity level grouping compensates for differences in the amount of needed treatment and resources, which affect the cost of treating the patient.

The data are presented for Tennessee hospitals having six or more cases falling into a particular DRG severity group. In certain reports some hospitals will not be listed because there was no DRG severity group with six or more cases reported from that facility. Also, certain DRGs that contained ungroupable records or were of a residual or "catch-all" definition were omitted from these reports.

For the purpose of comparability certain discharges were deleted from the reports. This included those patients with no charge or with a zero or negative charge. Also deleted were patients that transferred from an acute care or critical care hospital, patients that were discharged to a general or critical care hospital, and those patients that left against medical advice or that discontinued care.

Discharge records to the Department of Health are limited in the number of diagnoses and procedures that can be reported. An occasional severe case may exceed these limits and certain diagnoses and/or procedures might not be reported. This could result in an under-estimation of the severity of that discharge.

To see the hospital data for one of the fifty (50) DRGs in this report, go to page 3 and click anywhere on the line containing the selected DRG. Hospitals reporting that DRG are listed in county order and sorted alphabetically by hospital name within each county. Each hospital's data is on one row of the report. The last line in each report is the state total giving information based on all the discharges in Tennessee for that APR-DRG.

Using the Charge Report

To explain the use of these data look at the report below for "Pulmonary Edema & Respiratory Failure (DRG133)". In this example only one hospital is shown for illustration purposes. The first row provides information for Anderson County's Methodist Medical Center of Oak Ridge. In 2009, 61 cases of pulmonary edema were reported at this facility in the moderate severity group. These 61 cases had a median charge of \$11,412 (rounded to the nearest dollar amount). A total of 132 cases were reported in the major severity

level, having a median charge of \$16,446 and 128 cases fell into the severe group, having a median charge of \$33,141. Fewer than six cases fell into the minor severity group and as a result, this information was not reported.

Conclusion

The purpose of these reports is to show comparative charges among Tennessee hospitals for performing comparable treatments at similar levels of difficulty and complexity. This information, while not an exact representation of the actual cost per patient, provides useful information to public health researchers, business analysts, and the general public.

For more information, contact the Tennessee Department of Health, Division of Health Statistics at 615-741-4939 or at HealthStatistics.Health@state.tn.us.

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2009 TENNESSEE HOSPITAL DISCHARGE DATA Number of Cases and Median Charges (\$) Based on APR-DRGs* By Hospital Name and County Location

PULMONARY EDEMA & RESPIRATORY FAILURE (DRG 133)

County	Hospital Name	Minor Number	Charge	Moderate Number	Charge	Major Number	Charge	Severe Number	Charge
Anderson	0120 Methodist Medical Ctr. Oak Ridge	.	.	61	11,412	132	16,446	128	33,141
State	All Hospitals	39	15,236	1,846	14,379	3,420	20,748	3,131	37,181

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TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE OR ECMO (DRG 004)

TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE (DRG 005)

CRANIOTOMY EXCEPT FOR TRAUMA (DRG 021)

EXTRACRANIAL VASCULAR PROCEDURE (DRG 024)

CVA & PRECEREBRAL OCCLUSION W INFARCT (DRG 045)

MAJOR RESPIRATORY & CHEST PROCEDURES (DRG 120)

RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS (DRG 130)

PULMONARY EDEMA & RESPIRATORY FAILURE (DRG 133)

MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS (DRG 137)

OTHER PNEUMONIA (DRG 139)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (DRG 140)

CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT (DRG 161)

CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION (DRG 162)

CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION (DRG 163)

CORONARY BYPASS W CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE (DRG 165)

CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC PROCEDURE (DRG 166)

PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK (DRG 171)

PERCUTANEOUS CARDIOVASCULAR PROCEDURES W AMI (DRG 174)

PERCUTANEOUS CARDIOVASCULAR PROCEDURES W/O AMI (DRG 175)

ACUTE MYOCARDIAL INFARCTION (DRG 190)

CARDIAC CATHETERIZATION W CIRC DISCORD EXC ISCHEMIC HEART DISEASE (DRG 191)

CARDIAC CATHETERIZATION FOR ISCHEMIC HEART DISEASE (DRG 192)

HEART FAILURE (DRG 194)

CARDIAC ARRHYTHMIA & CONDUCTION DISORDER (DRG 201)

MAJOR SMALL & LARGE BOWEL PROCEDURES (DRG 221)

OTHER DIGESTIVE SYSTEM DIAGNOSES (DRG 254)

LAPAROSCOPIC CHOLECYSTECTOMY (DRG 263)

DISORDERS OF PANCREAS EXCEPT MALIGNANCY (282)

HIP JOINT REPLACEMENT (DRG 301)

KNEE JOINT REPLACEMENT (DRG 302)

DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK (DRG 304)

HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT (DRG 308)

KNEE & LOWER LEG PROCEDURES EXCEPT FOOT (DRG 313)

SHOULDER, UPPER ARM & FOREARM PROCEDURES (DRG 315)

CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP (DRG 321)

CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS (DRG 383)

RENAL FAILURE (DRG 460)

KIDNEY & URINARY TRACT INFECTIONS (DRG 463)

UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA (DRG 513)

CESAREAN DELIVERY (DRG 540)

VAGINAL DELIVERY (DRG 560)

NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM (DRG 640)

CHEMOTHERAPY (DRG 693)

INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE (DRG 710)

SEPTICEMIA & DISSEMINATED INFECTIONS (DRG 720)

POST-OPERATIVE, POST TRAUMATIC, OTHER DEVICE INFECTIONS (DRG 721)

MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES (DRG 751)

BIPOLAR DISORDERS (DRG 753)

REHABILITATION (DRG 860)

MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA (DRG 912)



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