

# ROMANIA AND THE INTERNATIONAL PATIENT CLASSIFICATION SYSTEM CONTEXT

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*Patient Classification System International (PCSI) Association represents an international organization where different professionals, administrators, decision makers etc. could have a continuous forum to discuss and debate current uses and future innovations related to Casemix classification and financing concepts. The Romanian participation of NSPHHSM specialists at the 25<sup>th</sup> PCSI Conference was the opportunity for making a comparative analysis of Romania with other countries which use or are in process of adopting the DRG system. The main conclusions of this analysis include: the need for a clear and coherent strategy of DRG development, better financial resources and support for the human resources from central and hospital level, improvement of the codification and data collection/reporting monitoring, development of the legal framework regarding fraud and an improvement of the communication between the actors involved in the system. We could say that Romania started in a good direction through the development and introduction of the DRG system, but it's necessary to push for more efforts, professionalism and support from the decision-makers in order, not just to keep the system working, but to be sure of achieving the goals established at the moment of their implementation.*

Every fall, the Patient Classification System International (PCSI) association hold its annual Conference with the aim of sharing the knowledge, experiences, problems or successes of the public health professionals involved in patient classification systems from around the world. The PCSI Conference in 2009 was a special edition, celebrating 25 years from the first edition. The small association with European vocation (*Patient Classification System Europe – PCSE*) founded in 1987 with a French president and a Dutch secretary is now a true international organization with more than 200 members coming together from all across the world. This new development was also the reason for changing (updating) its name from a European organization to an International one.

The roots of this association concerning patient classification lies in the development of the Diagnosis Related Groups (DRG) system during the '70 and '80, which gave birth to the idea of an international organization where different professionals, administrators, decision makers etc. could have a continuous forum to discuss and debate current uses and future innovations related to Casemix classification and financing concepts. From an initial focus on the DRG system, the association's goals have expanded to include a broader interest in classifying chronic and ambulatory patients, expanding clustering and grouping techniques using clinical and administrative data, all with a focus on improving health care management, financing, and quality of care.

Over the last 10 years, many countries, including Romania, have introduced various models of case-mix financing based on DRGs and as a result Romanians specialists

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became PCSI members over 10 years ago. The first DRG pilot projects in Romania occurred from 1996-1999. In fact, the PCSI association and its annual Conferences represented not only a "school" for Romanian specialist, but also a place to share local developments, successes and problems encountered in DRG implementation in Romania. Beginning in calendar year 2002, Romania officially introduced the DRG system and PCSI added yet another country to its list of members. Long-standing PCSI members and leaders welcomed Romanian colleagues interested in the international experience with great warmth the enthusiasm.

In 2009, the 25<sup>th</sup> PCSI Conference was held in Fukuoka, Japan, which has developed and implemented a local version of the DRG system named DPC (*Diagnosis Procedure Combinations*). The Romanian participation at this Conference targeted the presentation of two materials developed by the National School of Public Health and Health Services Management (NSPHHSM) regarding the utilization of the patient clinical data in evaluation of cancer burden, and the impact of Romanian change in the patient classification system, from the HCFA DRG version 18.0 patient classification system to AR-DRG version 5.0. The Romanian presentations generated great discussion and interesting debates among participants attending the conference and were regarded by specialists from around the world who have much experience with DRGs as interesting and advanced in raising questions and answers about how and what information can be aggregated using case-mix data. Romanian specialists attending the conference were updated on the

progress being made in other countries; either those who are expanding their initial case-mix works or those such as Brazil, Moldova, and Mongolia who are taking their first steps with studying and implementing case-mix concepts.

A comparative analysis of Romania with other countries which use or are in process of adopting the DRG system allowed us to draw several conclusions:

1. Romania is a country with 10 years of experience in DRG utilization and no longer represents a country with a health system at its beginnings in DRG utilization. From 2000 to 2010, Romania has worked hard to gain much experience during which most of the actors understood the essential parts of the system. However, what appears to be missing at this moment in Romania is a clear vision about future developments. Some potential development directions could be the followings: an emphasis on equitable hospital financing based on DRG, improved accuracy of the patient classification system, an improved monitoring system, increased hospital efficiency etc.

Unfortunately, the lack of a clear strategy and action plans for 2007-2009 led to a stagnation within the system, an ignorance of its benefits (better transparency, payment based on results etc.) and an accentuation of its weak aspects (changing the reported hospital morbidity, increasing the erroneous reports, the tendency to fraud the system through increased patients and Case Mix Index - CMI, quick discharges or transfers of the patients etc.).

2. Ongoing DRG system development and refinement activities require important resources, that are not only financial, but also human - human resources, both at the central and hospital level are a necessity to see the next level of benefits from DRGs in Romania. From this perspective, it is clear that the lack of good knowledge, at the hospital level, regarding the diagnosis and procedures coding made possible this important change in hospital reported morbidity in 2008-2009. For example, in Romania, in 2009 for the ENT department, the most frequent DRGs were for "Intubation" instead of the usual ones for "Tonsillectomy" and "Adenoidectomy". Others countries' experience shows that it is necessary to implement a good system of training and continuous education in the field of the diagnosis and procedures coding. This aspect is more important in countries like Romania where there is no formally recognized "coding profession" leading to physicians and nurses responsible for coding. With no formal training, with frequent staff changes, and with coding and system changes, it is difficult for these individuals to maintain and increase their knowledge yet if coding drives payments, then this becomes critical to invest in - either in terms of training existing physicians and nurses, or in creating a coding profession concept in Romania. Creating a more formalized training system could also serve as the basis for

classification system to better reflect Romanian hospital reality.

3. There are some prerequisites for obtaining correct results in hospital financing using the DRG: the complete transparency of hospital funds allocation and the existence of a clear policy with defined objectives and long term goals regarding hospital financing. The actual situation in Romania meets few of the presented prerequisites, being encumbered by some local particularities:

- There is not yet a system for calculating the local cost-weights for the DRG groups;
- The policies of hospital reimbursement and tariffs establishment are more attached to the „historic model” rather than to objective criteria for hospital resource allocation;
- The current laws and regulations in place give hospital managers incentives to increase their CMI in order to preserve their position;
- The National Health Insurance House (NHIH) funds are profoundly affected by the global economic crisis etc.

Consequently there are several voices within the health care system which question the utility of the DRG system for hospital financing, considering that there is a lack of some clear objectives which could led to a better hospital efficiency and an improved quality of serviced for the patients.

The experience of other countries where the DRG system works and produces good results shows that it is compulsory to have strong institutions involved in hospital reports monitoring and to develop a clear set of regulations regarding the entire process of documentation, classification, coding, data processing and collection of patient level clinical information. These aspects are more important in the countries where are functioning several firms specialized on hospital revenue maximization through the DRG system. Consequently, it appears a competition for hospital morbidity adjustment rather than for better and high quality hospital services. Meanwhile, it's recommended that mechanisms for involving hospitals in monitoring and evaluating their own activities be developed as it's clearly in each hospital's best interest to have a robust and fair resource allocation system. Because the total budget of NHIH for hospitals care is capped, the allocation of more funds towards the hospitals with increased CMI (due to erroneous/frauds reports) cuts the availability of funds for the remaining hospitals.

Monitoring and evaluation activities must be enhanced together with the development of clear rules regarding DRG "fraud". Both the U.S. and EU countries are using the DRG system together with clear penalties for hospitals which don't apply correct coding rules and standards, or those who report patient level data that doesn't

correspond with the official document of the case or with the provided health care services. For example, in the U.S. erroneous coding is not tolerated and when detected is considered fraud. The U.S False Claims Act is the government's primary civil tool to combat fraud and abuse in federal programs and procurement. The Act allows the government to recover triple the amount of its actual damages, plus a civil penalty of \$5,500 to \$11,000 for each false claim and permits the payment of a portion of any settlement or judgment under the Act to individuals who bring fraud to the attention of authorities. This result in very serious actions being taken with huge penalties and even jail time for people involved in federal fraud using hospital upcoding. As long as Romanian legislation considers the phenomena of upgrading the patients pathology in order to gain more funds just "an error" (which in the worst situation could lead to the funds return), the up coding will increase and will create a lot of dissatisfaction at the level of hospital sector.

Continuous development of the DRG system is not a fashion, but merely a necessity. The demographic changes, the technological updates, the introduction of new procedures, the economic environmental changes, the hospital managerial and functional modifications etc. are causes for a permanent development of the DRG system. In order to have this development is compulsory to build effective communication ways with hospital, for understanding of their reality, to increase the capacity of the central institutions (NHHH, Ministry of Health etc.) in

designing and answering the new challenges. Also it's necessary to keep continuity at the level of human resources, to develop new structures/organizations to deal with updating the clinical rationale of the classification and also to integrate the functioning of the DRG system with the rest of changes introduced by the continuous health sector reform.

Finally, we could say that Romania started in a good direction through the development and introduction of the DRG system, but it's necessary to push for more efforts, professionalism and support from the decision-makers in order, not just to keep the system working, but to be sure of achieving the goals established at the moment of their implementation.

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Information for Participants

**PCSI**

Main Theme:  
*Casemix: a common language for health sector innovation*

Date: November 11-14, 2009 Venue: ACROS Fukuoka  
 President: Prof. Kiyoshi NISHIOKA (President of DPC committee, MHLW)  
 Secretary: Prof. Shinya MATSUDA (Chief researcher of DPC project)