moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM069
Policy Title:	Facility DRG Validation & Outlier Review		
Section:	Facility-specific	Subsection:	Inpatient

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☐ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms) For Inpatient hospital services reimbursed by MS-DRG payment methodologies.
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	10/12/2009	Initially Published:	5/9/2019
Last Updated:	4/3/2024	Last Reviewed:	4/10/2024

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

Last Update Effective Date for Texas:	4/10/2024

Reimbursement Guidelines

A. General Policy Statement

We review DRG claims to confirm accuracy of payment. Reviews may occur pre-payment or post-payment and may include validation of DRG assignment and/or outlier payment review (if applicable).

B. Assigning and Supporting the DRG

1. The discharge date on the claim determines the DRG assignment. (CMS[6])
    a. The DRG and principal diagnosis are confirmed upon discharge, not based on the clinical suspicion at the time of admission.
    b. The discharge status is also determined upon discharge.
2. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter.

3. Clinical findings and physician documentation in the medical record must support all diagnoses and procedures billed, including the Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC) that would affect the billing.
4. We will not allow reimbursement for diagnoses, procedures, MCCs or CCs that are not clearly documented in the medical record.

C. DRG Validation Reviews

1. We conduct DRG validation reviews both pre-payment and post-payment to confirm DRG assignment and accuracy of payment.
2. DRG validation includes, but is not limited to the following:
   a. Verification of the diagnostic code assignments
   b. Verification of the procedural code assignments
   c. Verification of present on admission indicator assignments
   d. Verification of the sequencing of codes
   e. Verification of DRG grouping assignment and associated payment
   f. Verification of the MCC and CC when reported
3. DRG validation involves review of claim information (including but not limited to primary and secondary diagnosis codes) and medical record documentation when needed to determine correct coding on a claim submission and in accordance with industry coding standards as outlined by the Official ICD-10-CM Coding Guidelines, the applicable ICD Coding Manual, Uniform Hospital Discharge Data Set (UHDDS), and/or Coding Clinics.
4. When medical record documentation is needed, the DRG validation determination will be made using the medical record documentation available at the time of review.
5. Validation Results and Reimbursement Adjustments
   1. When the DRG reported on the claim does not match the DRG assigned in our DRG grouper, after all the submitted claim data is entered, the incorrect DRG will be changed to the DRG assigned by the grouper.
   2. Review findings will communicate the official industry sourced documents, including Official ICD-10-CM Coding Guidelines, the applicable ICD Coding Manual, UHDDS guidelines and Coding Clinics.
   3. DRG validation reviews may result in revisions to the diagnosis codes and/or procedural codes. These revisions may result in a change in the DRG assignment. Refunds will be requested as appropriate.

D. DRG Outlier Reviews

1. If the DRG claim has an outlier payment, a line item review of an itemized bill may be performed.
2. Audit findings may result in a reduction or elimination of outlier payments. Refunds will be requested as appropriate.

3. The purpose of auditing an itemized bill is to evaluate a claim to determine whether it contains charges for supplies or services that are either routine and/or integral and necessary components of underlying daily services or procedure charges.
    a. All such identified charges are denied as unbundled and therefore not separately reimbursable.
    b. Refer to Cross References for other policies addressing some specific areas of possible unbundling or items not eligible for separate reimbursement.
    c. The denied charges are then excluded from the total charge of the claim and the outlier is calculated using the adjusted amount.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CAH	=	Critical Access Hospital
CC	=	Complication or Comorbidity (see also related listing: MCC)
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
ED	=	Emergency Department (also known as/see also ER)
ER	=	Emergency Room (also known as/see also ED)
HAC	=	Hospital Acquired Condition
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HFMA	=	Healthcare Financial Management Association
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
MCC	=	Major Complication or Comorbidity (see also related listing: CC)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)

Acronym or Abbreviation		Definition
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NUBC	=	National Uniform Billing Committee
NUCC	=	National Uniform Claim Committee
POA	=	Present on Admission
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
TOB	=	Type of Bill
UB	=	Uniform Bill
UHDDS	=	Uniform Hospital Discharge Data Set

Definition of Terms

Term	Definition
Additional (Other) Diagnoses	Additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring; or has implications for future health care needs (for neonates only). The Uniform Hospital Discharge Data Set (UHDDS) defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."
DRG Validation	Review to verify the accuracy of the hospital's ICD coding of all diagnoses and procedures that affect the DRG. (CMS[5])
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	A morbidity classification system for classifying diagnoses and reason for visits in all health care settings for the purpose of coding and reporting. Valid for dates of service 10/1/2015 and following.
Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC)	The severity of the illness or condition is determined by the presence or absence of MCCs and CCs. The presence of these will impact the DRG assignment and subsequent hospital payment.

Term	Definition
Medicare Severity Diagnosis Related Groups (MS-DRG or DRG)	A statistical system of classifying any inpatient stay into groups for the purposes of payment. DRGs are assigned by a "grouper" program based on ICD (International Classification of Diseases) diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities.
Present on Admission (POA) Indicator	Condition(s) present at the time the order for inpatient admission occurs. The POA indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission.
Principal Diagnosis	The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

"For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

"The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

"Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). The UHDDS definitions also apply to hospice services (all levels of care).

"The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-10-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous conditions

"If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the

diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

"However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

B. Abnormal findings

"Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

"Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. Uncertain Diagnosis

"If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out" or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

"Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals." (CMS[1], CMS[4])

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Diagnosis Code Requirements - Level of Detail, Number of Characters, and Laterality." Moda Health Reimbursement Policy Manual, RPM053.

C. "Diagnosis Code Requirements - Invalid As Primary Diagnosis." Moda Health Reimbursement Policy Manual, RPM054.

D. "Facility Guidelines, General Overview." Moda Health Reimbursement Policy Manual, RPM065.

E. "Facility Reimbursement of Respiratory Therapy Services." Moda Health Reimbursement Policy Manual, RPM047.

F. "Hospital Routine Supplies and Services." Moda Health Reimbursement Policy Manual, RPM043.

G. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

H. "Robotic Assisted Surgery." Moda Health Reimbursement Policy Manual, RPM006.

I. "Routine Venipuncture and/or Collection of Specimens." Moda Health Reimbursement Policy Manual, RPM012.

References & Resources

1. CMS. "ICD-10-CM Official Guidelines for Coding and Reporting, FY 2019." Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf . Last updated October 1, 2018; Last accessed April 23/2019.

2. CMS. "ICD-10-CM Official Guidelines for Coding and Reporting, FY 2018." Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf . Last updated October 1, 2017; Last accessed April 23/2019.

3. CMS. *Centers for Medicare & Medicaid Services (CMS) Pub. 100-04 Claims Processing Manual.* Chapter 23 – Fee Schedule Administration and Coding Requirements.

4. CMS. "ICD-10-CM Official Guidelines for Coding and Reporting, FY 2019." Centers for Medicare and Medicaid Services (CMS). § III.A,B,C. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf . Last updated October 1, 2018; Last accessed April 23/2019.

5. CMS. "DRG Validation Review, et al." Medicare Program Integrity Manual, Pub. 100-08, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services, §6.5, 6.5.1, 6.5.2, 6.5.3, 6.5.4, 6.5.6.

6. CMS. "Design and development of the Diagnosis Related Group (DRG)." Last updated October 2019; Last accessed April 3, 2024. https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf .

Background Information

MS-DRGs are a CMS payment methodology that provides a case-rate payment for the episode of care based on the DRG classification or grouping of care assigned. Complications and comorbidities reported on the claim affect the DRG assignment and the reimbursement for the care.

The CMS DRG payment methodology and the related rules are considered an industry-standard for many Commercial plans and carriers in developing their contracts and policies.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be

fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
4/10/2024	Clarification/Update: Section B.1: Added for clarification on DRG groupers. References & Resources: Added 1 entry. Minor rephrasing, no content changes.
11/9/2022	Format/Update Document Title Updated. Scope, States: Idaho added. Section A: Revised & reworded to include outlier reviews. Section D DRG outlier reviews: Added. These have been occurring, just not previously mentioned in policy; so not subject to 28 TAC. Cross References: 4 entries added. Hyperlinks added.
6/8/2022	Format/Update: Change to new header. Acronym Table: 5 entries added. Policy History Section added. Entries prior to 2022 omitted (in archive storage).
5/9/2019	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/12/2009	Original Effective Date (with or without formal documentation). Policy based on CMS DRG guidelines. (CMS[5])