Reimbursement Policy

Diagnosis Related Group Validation

REIMBURSEMENT POLICY NUMBER: 76

Effective Date: 8/1/2025

Last Review Date: 7/2025

Next Annual Review: 7/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

☐ All health care services billed on UB04 forms (CMS 1450)

Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

Plan Product:

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☒ DRG

☒ Modified DRG

☐ Percentage of billed charges/per diem

POLICY STATEMENT

Note: This policy applies to all inpatient facility claims reimbursed under the Medicare Severity Diagnosis Related Groups (MS-DRG) methodologies submitted by contracted hospitals.

I. Inpatient hospital stays reimbursed under a DRG payment methodology are subject to either a pre-or-post payment validation review to confirm accurate coding and adherence to clinical documentation guidelines.

II. DRG validation involves review of claim information and/or medical records documentation to determine correct coding on a claim in accordance with CMS and industry-standard coding rules.

III. DRG validation reviews will include, but are not limited to:

A. Coding accuracy review, including diagnosis and procedure code assignments
B. Review of present on admission (POA) indicators
C. Review of the sequencing of codes
D. When reported, verification of the MCC and CC
E. Verification of the DRG assignment and associated payment

IV. If the validation review determines the billed DRG is not supported based on the claim information, medical records documentation, and/or industry-standard coding rules, then **one** of the following reimbursement methodologies (A. **or** B.) will apply:

A. For pre-payment reviews: the **reimbursement will be adjusted to the appropriately assigned DRG**.
B. For post-payment reviews: **overpayments will be recouped** through standard payment recovery processes.

Note: Facilities will be notified of the findings and may request a reconsideration in accordance with Providence Health Plan's provider dispute process.

POLICY GUIDELINES

PURPOSE

To outline Providence Health Plan's policy for Diagnosis Related Group (DRG) validation and ensure that inpatient hospital reimbursement is consistent with the level of services provided and accurately reflects the documented clinical information.

ASSIGNING AND SUPPORTING THE DRG

DRGs are assigned based on the principal diagnosis, secondary diagnoses, procedures performed, patient age and discharge status, and are grouped using industry-standard DRG software in accordance with Medicare Severity (MS-DRG) or All Patient Refined (APR-DRG) methodologies.
All diagnoses and procedures submitted must be:

- **Clinically supported** by documentation in the patient's medical record
- **Coded according to official guidelines** (e.g., ICD-10-CM/PCS, CMS coding instructions, Coding Clinic guidance)
- **Relevant to the care rendered** during the covered inpatient stay

Providence Health Plan requires that facilities maintain clear, legible, and complete documentation to substantiate each code that impacts the DRG assignment. The medical record must demonstrate the presence, clinical relevance, and active management of each condition or procedure coded. This includes, but is not limited to:

- Physician documentation (progress notes, H&P, discharge summary)
- Operative reports
- Diagnostic findings (labs, imaging, pathology)
- Nursing and ancillary documentation

Failure to support the assigned DRG through adequate documentation may result in claim adjustments, denials, or recoupment of payment following DRG validation review.
Providence Health Plan reserves the right to conduct DRG validation reviews to ensure compliance with this policy and to promote accurate and appropriate reimbursement practices.

DOCUMENTATION REQUIREMENTS

In order to provide an effective and accurate review, the following documentation **must** be provided. If any of these items are not submitted, the review may be delayed, and any decision outcome could be affected:

- Inpatient Medical Record
    - H&P
    - Progress notes
    - Consults
    - Operative notes
    - Procedure notes (i.e. EGDs, Cardiac Caths, Bedside procedures, etc.)
    - IR radiology notes
    - Physician orders

- Medication orders/lists
- Emergency department notes
- Discharge summary
- As needed:
    - Wound care notes
    - Respiratory therapy notes
    - Pathology results
    - Radiology notes
    - Nursing notes

VALIDATION RESULTS AND REIMBURSEMENT ADJUSTMENTS

Facilities will be notified of any DRG validation resulting in a reimbursement adjustment or recoupment. Review findings will communicate the industry-standard coding rationale used to support the reimbursement adjustment. Facilities may request a reconsideration or appeal in accordance with Providence Health Plan's provider dispute process.

For pre-payment reviews, the reimbursement will be adjusted to the appropriately assigned DRG. For post-payment reviews, overpayments will be recouped through standard payment recovery processes.

DEFINITIONS

DRG (Diagnosis Related Group)

A classification system that groups hospital cases into categories based on diagnosis, procedures, age, sex, discharge status, and the presence of complications or comorbidities.

DRG Validation

The process of confirming that the DRG assigned to a claim is supported by clinical documentation and complies with official coding guidelines.

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.

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.

International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS)

A medical classification system that assigns codes to procedures in hospitals and inpatient settings for the purpose of coding and reporting.

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.

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.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses inpatient hospital MS-DRG Assignment and Coding Validation:

- Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements
- CMS, NCHS, AHA, & AHIMA. "Use of Sign/Symptom/Unspecified Codes." ICD-10-CM Official Guidelines. Section I.B.18.
- CMS. 42 CFR §405.929- Post-Payment Review
- CMS. 42 CFR §405.930- Failure to Respond to Additional Documentation Request
- CMS. 42 CFR §405.986- Good Cause for Reopening
- Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §20- Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs) §§20.1.2.4. B & C, 40.2.4
- Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions, §§3.1.A , 3.2.A- 3.6.6
- Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review, §6.5.4 – Review of Procedures Affecting the DRG
- Inpatient Prospective Payment System (IPPS) Final Rule and Correcting Amendment Tables: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page
- CMS. ICD-10 Clinical Modification (ICD-10-CM) and ICD-10- Procedural Coding System (PCS) (ICD-10-PCS) Coding Manual, Official Guidelines for Coding and Reporting and Addendums
- AHA Coding Clinic for ICD-10

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding inpatient hospital MS-DRG Coding Validation.

BILLING AND CODING GUIDELINES

These billing and coding guidelines support the accurate processing and reimbursement of inpatient hospital claims reimbursed under a Diagnosis Related Group (DRG) methodology by Providence Health Plan.

1. **Principal Diagnosis**

- The principal diagnosis must identify the condition chiefly responsible for the inpatient admission, determined after study, and be clearly documented by the attending provider.
- Use of symptom codes as the principal diagnosis is only appropriate when a definitive diagnosis is not available.

2. **Secondary Diagnoses**
   - All clinically significant comorbid conditions and complications that impact the care provided or DRG grouping must be reported.
   - Only include conditions supported by the medical record and consistent with official coding guidelines.
3. **Procedures**
   - Procedure codes must be reported for all therapeutic or diagnostic interventions performed during the inpatient stay that meet reporting criteria.
   - Accurate sequencing of procedures is required, especially when multiple procedures influence DRG assignment.
4. **Present on Admission (POA) Indicators**
   - POA indicators must be reported for each diagnosis code (unless exempt) and must be clinically accurate and supported.
   - Incorrect POA assignment may result in DRG downgrades or HAC-related payment adjustments.
5. **Discharge Disposition**
   - The patient's discharge status must be coded accurately, as this can affect DRG reimbursement (e.g., transfers to another acute facility, hospice, or SNF).
   - Providence Health Plan follows CMS post-acute transfer rules unless otherwise specified by contract.

CROSS REFERENCES

- Inpatient Hospital Admissions and Length of Stay Reviews, RP7
- Preventable Adverse Events, RP73
- Transfers Between Hospitals, RP75

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS): ICD-10 Official Guidelines for Coding and Reporting; https://www.cms.gov/medicare/coding-billing/icd-10-codes; Last Accessed: 5/27/2025
2. Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements 10.1 – General Rules for Diagnosis Codes, 10.2 – Inpatient Claim Diagnosis Reporting; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf; Last Accessed: 5/27/2025
3. Medicare Hospital Prospective Payment System How DRG Rates Are Calculated and Updated, Office of Inspector General, Office of Evaluations and Inspections, Region IX, White Paper, August 2001; https://oig.hhs.gov/reports/all/2001/medicare-hospital-prospective-payment-system-how-drg-rates-are-calculated-and-updated/; Last Accessed: 5/27/2025

4. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §20- Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs); https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf; Last Accessed: 5/27/2025
5. Medicare Program Integrity Manual, Chapter 3- Verifying Potential Errors and Taking Corrective Actions; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf; Last Accessed: 5/27/2025
6. Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services; https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c06.pdf; Last Accessed: 5/27/2025
7. ICD-10-CM Official Guidelines for Coding and Reporting | FY 2025; Updated October 1, 2024; https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf; Last Accessed 5/27/2025
8. ICD-10-PCS Official Guidelines for Coding and Reporting 2025; Updated October 1, 2024; https://www.cms.gov/files/document/2025-official-icd-10-pcs-coding-guidelines.pdf; Last Accessed 5/27/2025
9. United States. National Committee on Vital and Health Statistics. (1980). Uniform hospital discharge data (UHDDS): minimum data set : report of the National Committee on Vital and Health Statistics; https://stacks.cdc.gov/view/cdc/103162; Last Accessed 5/27/2025

POLICY REVISION HISTORY

Date	Revision Summary
6/2025	New policy