Facility DRG Validation & Outlier Review

Last Updated: 6/3/2025 **Last Reviewed: 6/11/2025** **Originally Effective: 10/12/2009**

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

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM069**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

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 DRG assignment is based on data elements not available until the discharge date. [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. Determining Which DRG Fee Schedule Applies to the Claim

1. Facility/Inpatient claims are assigned to a single agreement date.
   When the claim's admission and discharge dates span a change in agreement effective dates, line items are never priced based on the line-item date of service; all line items on the entire claim are priced based on the same agreement date.
2. The admission date on the claim determines the agreement effective date or DRG fee schedule effective date which applies for pricing the claim (not the DOS of individual line items, and not the discharge date). We recognize this is different than how CMS determines which DRG fee schedule applies when an inpatient stay spans different fee schedule periods. However:
   a. This is due to a hard system limitation which uses the admission date to determine both the member benefit level and the pricing of the Inpatient claim.
   b. This is designed to ensure a member does not lose coverage should their eligibility status change during the inpatient stay.
   c. This system limitation cannot be bypassed or customized.

d. Processing based on admission date is consistent with the medical insurance industry standard of non-interruption of coverage during an inpatient hospital stay.

D. 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
   a. 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.
   b. 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.
   c. 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.

E. 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 Related Policies 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.

Definitions

Acronyms/Abbreviations

Acronym	Definition
CC	Complication or Comorbidity (see also related listing: MCC)
CMS	Centers for Medicare and Medicaid Services
DRG	Diagnosis Related Group (also known as/see also MS DRG)
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)
POA	Present on Admission
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
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. [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.
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.

Term	Definition
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.

Related Policies

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.

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 .

Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
6/11/2025	Clarification of determining the effective date for the DRG pricing/fee schedule. Acronyms & formatting updated. No policy changes.
4/10/2024	Clarified DRG groupers. Resources updated. Minor rephrasing, no poicy changes.
11/9/2022	Revised & reworded to include outlier reviews; these have been occurring, just not previously mentioned in policy; so not subject to 28 TAC. Idaho added to Scope. Title & Related Policies updated. No policy changes.
6/8/2022	Policy History Section added. Entries prior to 2022 omitted (in archive storage). Acronyms updated. Formatting updates. No policy changes.
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. [5]