PI Payment Policy 25
DRG Clinical Validation

All States & Lines of Business

Purpose

The purpose of the DRG Clinical Validation Payment Policy is to support compliance with the coding and billing of a claim submitted to Molina Healthcare both pre-payment and post-payment, to ensure accurate hospital DRG reimbursement. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as well as the member's benefit plan document always supersede the information in a payment policy. Additionally, to the extent there are any conflicts between the payment policy and the provider contract language, the provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Overview

Molina Healthcare or designee conducts DRG clinical validation reviews both pre-payment and post-payment to confirm DRG assignments and appropriate payment. This helps to ensure that claims represent the services provided to our members, and that billing and reimbursement is compliant with federal and state regulations as well as applicable standards, rules, laws, policy and contract provisions.

Process

Correct DRG assignment will be in accordance with industry coding standards:

(a) Official ICD-10-CM Coding Guidelines
(b) Applicable ICD Coding Manual
(c) Uniform Hospital Discharge Data Set (UHDDS), and/or
(d) Coding Clinics

The DRG and principal diagnosis assigned represent the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care and not based on clinical suspicions at the time of admission. The DRG clinical validation determination will be made using the medical record documentation available at the time of review and must support all diagnoses and procedures billed, including Major Complication or Comorbidity (MCC) and Complication or Comorbidity (CC) and Severity of Illness.

DRG clinical validation includes, but is not limited to, verification of the following:

(a) Diagnostic code assignments
(b) Procedural code assignments
(c) Sequencing of codes
(d) DRG grouping assignment and associated payment
(e) MCC and CC and severity of illness (if applicable)

In the event that DRG clinical validation does not substantiate the billed DRG or is inconsistent with industry coding standards and requirements, Molina Healthcare may:

(a) Adjust the DRG to a DRG that is supported by the medical record documentation
(b) Adjust payment
(c) Request refunds
(d) Issue a base DRG payment

Facilities that disagree with a determination may follow appropriate procedures in accordance with regulatory and contractual requirements.

Coding

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

Approval History

TYPE	DATE	ACTION
Effective Date	1/7/2022	New Policy

References

1. AHIMA Work Group. “Taking Coding to the Next Level through Clinical Validation”. Journal of AHIMA 85, no. 1 [January 2014].
2. CMS. “Medicare Claims Processing Manual. Chapter 23 - Fee Schedule Administration and Coding Requirements.” Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
3. CMS. “Medicare Program Integrity Manual. Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services.” Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf
4. CMS. “ICD-10-CM Official Guidelines for Coding and Reporting. FY 2021.” Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

Supplemental Information

Definitions

Clinical Validation – Additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether the patient truly possesses the conditions and/or procedures that were documented in the medical record.

DRG Validation Review – According to the CMS Medicare Program Integrity Manual, Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services, 6.5.3 Medical Review of Inpatient Hospital Claims for Part A Payment DRG Validation Review, “The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician’s description and the information contained in the beneficiary’s medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.”

Other Diagnoses – The CMS ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, “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.”

Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the updated face sheet, it should ordinarily be coded on the claim. However, diagnoses for previously resolved conditions that have no bearing on the current stay are not to be reported or coded on the claim.

Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance as it relates to the current admission.

Principal Diagnosis – The CMS ICD-10-CM Official Guidelines for Coding and Reporting FY 2021, “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

Present on Admission Indicator (POA) - Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

Appendix