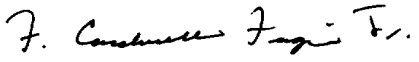
DRG Validation & Outlier Review
Policy No. 442
Policy and Procedure

Department	Claims Operations
Purpose	To audit DRGs to ensure regulatory compliance and appropriate payment.
Applicability	VIVA Providers and VIVA Auditors
Approved	
Approved	Cardwell Feagin, Jr.
Approver Title	Chief Operating Officer
Original Effective Date	01/01/2023
Revision Date	
Revision Number	1
Regulatory Requirement	N/A
Department	Claims

A. General Policy Statement

To ensure compliance with CMS and Department of Insurance VIVA reviews 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.
   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. VIVA 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's 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). VIVA recognizes 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. VIVA 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. Adjustments will be completed as appropriate.

E. DRG Outlier Reviews

Under the Inpatient Prospective Payment System ("IPPS") the Centers for Medicare & Medicaid Services ("CMS") pays hospitals a single, bundled payment for each Medicare inpatient discharge based on the Medicare Severity Diagnosis-Related Group ("MS-DRG") assigned to the case. With limited exceptions, Medicare does not pay separately for individual items or services furnished during an inpatient stay, including most devices. The costs of devices are generally considered to be included in the MS-DRG payment amounts, which are recalibrated annually to reflect changes in hospital resource utilization.

The general principle in IPPS is that all costs associated with an inpatient stay - including devices- are integral to or an inherent part of the MS-DRG. These devices, supplies and equipment include medical devices implanted in the body during a surgical procedure, as well as devices provided during a Medicare-paid inpatient or outpatient hospital service.

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. Adjustments will be completed 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. In IPPS the general principle is that the MS-DRG payment covers all operating and capital costs associated with an inpatient stay. As a result, in general all devices, supplies, and equipment used during inpatient procedures are considered bundled into the MS-DRG payment. The is that prospective payment rates are calculated based on historical cost data and are intended to reflect the average costs of providing care, including the costs of devices. Separate payment for these items would result in double

payment because their costs are already factored into the prospective payment rates. See Table 1 for review of devices and supplies that are generally considered bundled into the MS-DRG.

The denied charges are then excluded from the total charge of the claim and the outlier is calculated using the adjusted amount

Table 1: Devices and Supplies Included in the DRG

Category	Examples	Rationale for Bundled Payment
Surgical Instruments	Scalpels, forceps, retractors, clamps, scissors, needle holders, hemostats, surgical drills, bone saws, laparoscopic instruments, arthroscopic instruments	Costs recovered through depreciation as capital assets; reusable items whose costs are factored into MS-DRG relative weights
Disposable Surgical Supplies	Surgical sponges, gauze, drapes, surgical gowns, gloves, suction tubing, irrigation tubing, specimen containers, surgical prep kits, customized surgical kits	Routine supplies furnished incident to surgical services; costs included in historical data used to calculate MS-DRG weights
Routine Implantables	Standard orthopedic screws, plates, and pins; routine surgical mesh; standard vascular grafts; conventional pacemakers and defibrillators; standard joint replacement components	Costs reflected in MS-DRG relative weights based on historical claims data; no longer considered "new" for NTAP purposes
Wound Closure Materials	Sutures (absorbable and non-absorbable), surgical staples, surgical clips (except radiological site markers), wound closure strips, skin adhesives, standard surgical tape	Explicitly excluded under OPPS at 42 C.F.R. § 419.66(b)(2); costs incorporated into bundled payment[29]
Anesthesia Supplies	Endotracheal tubes, laryngeal mask airways, anesthesia circuits, IV catheters, syringes, needles, medication vials, pulse oximetry sensors, ECG electrodes	Standard supplies used in anesthesia administration; costs included in operating cost calculations used to determine MS-DRG weights
Operating Room Equipment	Surgical tables, operating room lights, electrosurgical units, suction apparatus, patient monitors, infusion pumps, warming devices	Capital equipment whose costs are recovered through depreciation and financing expenses; excluded under principles analogous to 42 C.F.R. § 419.66(b)(1)[30]
Standard Diagnostic Devices	Conventional imaging equipment, standard endoscopes, routine biopsy instruments, conventional monitoring devices	Established technologies whose costs are reflected in MS-DRG payment rates

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.
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.

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.
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 .
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.
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)." https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf .
7. https://www.govinfo.gov/content/pkg/FR-2003-03-05/pdf/03-5121.pdf.
8. https://www.govinfo.gov/content/pkg/FR-2024-10-03/html/2024-22765.htm.
9. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps- proposed-rule-home-page.
10. https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021929.
11. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy- manual.
12. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs- Items/CMS018912.
13. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/outlier-payments.
14. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/items- services-not-covered-under-medicare-text-only.pdf.
15. https://seed.nih.gov/sites/default/files/2024-01/Reimbursement-Knowledge-Guide-for-Medical-Devices.pdf
16. 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
17. 12 42 C.F.R. § 412.2(e) ("[T]he prospective payment system ... includes payment for inpatient operating costs ...
18. Medicare Benefit Policy Manual, Chapter 14 - Medical Devices.
19. 42 C.F.R. § 412.80.
20. 42 C.F.R. § 412.80(a)(1); 42 C.F.R. § 412.84.
21. https://www.govinfo.gov/content/pkg/FR-2003-03-05/pdf/03-5121.pdf.