Reimbursement Policy	
Subject: **Diagnoses Used in DRG Computation**	
Policy Number: **G-12005**	Policy Section: **Coding**
Last Approval Date: **03/15/2023**	Effective Date: **10/08/2020**

**** Visit our provider website for the most version of our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.healthybluemo.com**. ****

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Healthy Blue benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed codes are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These policies may be superseded by mandates in provider or state contracts, or state, federal, or CMS requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Healthy Blue reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to our provider website.

Policy

Healthy Blue ensures that the diagnosis and procedure codes that generate the Diagnosis Related Groups (DRG) are accurate, valid, and sequenced in accordance with national coding standards and specified guidelines unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Healthy Blue performs DRG audits to determine that the diagnostic and procedural information that led to the DRG assignment is substantiated by the medical record. The audits utilize coding criteria to limit the billed diagnosis used in DRG computation to the following: those that are relevant to the patient's care; those that impact the patient's outcome, treatment, intensity of service or length of stay; and those that are supported by documentation within the medical record.

Healthy Blue routinely monitors DRG billing patterns to ensure that hospitals perform fair and equitable coding and utilization.

Related Coding

Standard correct coding applies

Policy History

03/15/2023	Review approved: Policy template updated
01/01/2021	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contracts

Definitions

Diagnosis Related Groups (DRGs)	Diagnosis Related Groups (DRGs) are a patient classification method which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital.
General Reimbursement Policy Definitions	

Related Policies and Materials

Documentation Standards for an Episode of Care
Provider Preventable Conditions