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| **Policy Title** | Diagnosis Related Grouper (DRG) Validation Review Reimbursement Policy |
| **Policy Department** | Payment Strategy and Operations |
| **Effective Date** | 1/1/2022 |
| **Revision Date(s)** | 1/1/2022 |
| **Next Review Date** | |

**Disclaimer:**

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

## Description:

This policy addresses claims billed with Diagnosis Related Group (DRG) codes that are at an increased risk of incorrect billing. Claims are reviewed for coding correctness and providers notified of any adverse findings via letter.

## Definitions:

- **Diagnosis Related Group (DRG)**
  - This is a three digit billing code used for inpatient acute care claims. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

**Policy:**

DRG Validation Reviews are conducted by Clover Health to confirm DRG assignment and accuracy of payment. DRG validation involves review of claim information (including but not limited to all diagnoses, procedure codes, revenue codes) and/or medical record documentation to determine correct coding on a claim submission and in accordance with industry coding standards as outlined by the Official Coding Guidelines, the applicable ICD Coding Manual, UHDDS, and/or Coding Clinics.

Clover identifies, on a prepayment and post-payment basis, claims billed with certain DRGs and diagnosis codes at a high risk of incorrect coding. When claims meet the established criteria, a certified coder will review the claim for items including, but not limited to:

- Verification of the diagnosis code(s) billed
- Verification of the procedure code(s) billed
- Review of Present on Admission (POA) assignments
- Validation of the sequencing of codes
- Validation of the MCC and CC diagnosis codes, when billed

DRG Validation reviews will be performed using the medical record documentation available at the time of audit. If this review results in adverse findings for the facility, a letter will be sent notifying the provider of the DRG revision.

Clover shall perform these reviews using accepted principles of coding practice, consistent with guidelines established for ICD coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS.

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. Once the validation is completed, if the coding review results in an update to the DRG, a letter is mailed to the facility explaining the rationale for the DRG update. The claim will be processed at the payment rate of the revised DRG and message code stating "*Payer deems the information submitted does not support this level of service. Missing patient medical record for this service.*" will be appended to the paid line on the remittance.

The letter will detail the timeline for submission of records to support the billed DRG, if the provider disagrees with Clover's findings. If medical records are received, the documentation will be reviewed by a certified coder and medical director in order to verify the claim coding.

| References |
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| ICD-10-CM Official Guidelines for Coding and Reporting |
| Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements |
| CMS Inpatient Hospital DRG Review Program |
| Centers for Medicare & Medicaid Services (CMS) Program Integrity Manual, Chapter 6, Section 6.5.3 |
| Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Manual, Chapter 4, Section 4130 |