DRG Clinical Validation

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. 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 a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this 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. If there is a state exception, please refer to the state exception table listed below.

Policy 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.

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)

If 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.

Supplemental Information

Definitions

Term	Definition
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.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	01/07/2022	
Revised Date	12/12/2024	Updated Template

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

***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*.