DRG Validation

The Department of Health Care Policy & Financing (HCPF) and Health Management Systems, Inc. (HMS) will request medical records from providers to conduct post-payment reviews of acute inpatient hospital DRG paid claims to ensure hospitals are reimbursed accurately by verifying proper coding of all diagnoses and procedure codes, and accurate and complete recording of data elements that affect the Diagnosis-Related Group (DRG) assignment, as documented in the medical record.

DRG reviews will target claims to verify all diagnoses and procedure codes are billed appropriately in accordance with ICD-10-CM Official Guidelines for Coding and Reporting and Coding Clinics, and that the codes are consistent with the documentation in the medical record, resulting in accurate DRG assignment and reimbursement. The medical record will be reviewed with codes validated from both a coding and a clinical perspective. HMS will apply the coding guidelines in effect at the time the services were provided.

Coding validation will verify the codes are billed and sequenced in accordance with coding guidelines.

Clinical validation will verify the diagnoses coded are actually present based on the clinical documentation in the medical record, and the results of related diagnostic testing are consistent with the diagnoses.

The following elements are verified:

- All diagnosis codes billed on the claim were coded accurately and supported in the medical record.
- Procedure codes were coded accurately and supported in the medical record.
- The discharge status code and all other data elements affecting the DRG assignment and reimbursement were coded accurately.
- Any Hospital Acquired Condition (HAC) were coded with the correct Present on Admission (POA) indicator resulting in accurate DRG assignment and reimbursement.
- The clinical documentation and results of diagnostic testing support the billed diagnosis.

HMS will utilize ICD-10-CM Official Guidelines for Coding and Reporting, and Coding Clinics, as well as industry standard criteria and definitions to substantiate the billed diagnoses codes affecting DRG assignment.

For Clinical validation, the diagnoses documented in a patient's medical record are substantiated by criteria that are accepted by the medical community. These criteria typically come from professional guidelines and other evidence-based sources. For example, when utilizing the ICD 10 code for acute kidney injury, the 2016 Kidney Disease: Improving Global

Outcomes (KDIGO) conference definition will be utilized. The diagnosis of AKI is based on the individual patient's normal baseline creatinine, rather than the lab test's reference range.

Additional examples include but are not limited to:

- ICD-10-CM Official Guidelines for Coding and Reporting, Section II. Selection of a Principal Diagnosis.
- ICD-10-CM Official Guidelines for Coding and Reporting, Section II. C. Two or more diagnosis that equally meet the definition for principal diagnosis.
- ICD-10-CM Official Guidelines for Coding and Reporting, Section III, Reporting Additional Diagnoses.
- AHA Coding Clinic, Q3 2017. Severe Malnutrition, p 25.
- AHA Coding Clinic, Q4 2018. Body Mass Index, p 77.
- AHA Coding Clinic, Q4 2019.Body Mass Index, p 52.
- Improving Global Outcomes (KDIGO). Acute Kidney Injury Work Group. KDIGO clinical practice guidelines for acute kidney injury. Kidney Int Suppl 2012; 2:1.
- Singer, M, Deutschman CS, Seymour, CW, (2016). The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). JAMA. 315(8):801-810.

HMS utilizes reviewers who are licensed clinical staff with training and competency in accordance with industry standards. Experienced clinical staff including registered nurses, certified coders, and physicians trained in billing and coding guidelines and Colorado rules perform DRG Validation reviews utilizing standard guidelines per the above resources. Physicians have active, unrestricted U.S. medical licenses, are board certified in appropriate medical specialties and are familiar with Colorado laws and community practice standards.

After requested medical records submitted by a provider are reviewed, HCPF and HMS will identify DRG claims billed with potentially incorrect diagnoses, procedures, and other data elements that impact the DRG assignment and therefore, potentially incorrect hospital reimbursement. These claims are considered a potential overpayment and may be subject to recovery by HCPF. Prior to issuing notices of preliminary findings, the HCPF RAC medical director and HCPF coding staff will be involved in the review of preliminary findings.

Applicable Health First Colorado Program rules and references for this audit are listed below. Providers are required to follow all Health First Colorado rules including the Code of Colorado Regulations (CCR), ICD-10-CM Official Guidelines for Coding and Reporting, American Medical Association (AMA) medical coding rules, Health First Colorado (Colorado Medicaid) Provider Billing Manuals, Health First Colorado Provider Bulletins, Centers for Medicare & Medicaid (CMS) rules, and any other state or federal rules pertaining to billing for Medicaid services.

References:

Colorado Department of Health Care Policy & Financing General Provider Information Manual:

- "All Health First Colorado claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims."

- "The Health First Colorado program recognizes only those diagnosis codes published in the ICD-10-CM by the U.S. Department of Health and Human Services, Public Health Service and Centers for Medicare & Medicaid Services (CMS)."

- "ICD-10-CM codes must be entered properly on the claim form and must relate to the services for which charges are being submitted. The Health First Colorado program provides benefits for services that are medically necessary. The diagnosis code must be specific and indicate an appropriate cause for and relationship to the services provided."

- "Providers must assure that the diagnosis entered supports the validity and appropriateness of the billed service."

Colorado Department of Health Care Policy & Financing Inpatient/Outpatient (IP/OP) Billing Manual:

- "Inpatient Hospital Billing Information: Inpatient Hospital Services are reimbursed by Health First Colorado on a prospective basis using the All Patient Refined (APR) Diagnosis Related Group (DRG) method."

- "Hospital Service Payments – Inpatient Reimbursement: Hospitals designated as Prospective Payment System (PPS) hospitals are paid using the Diagnosis Related Group (DRG) methodology."

- "Present on Admission Indicators on Hospital Claims: Inclusion of "Present on Admission" (POA) indicator responses are required for inpatient hospital claims submitted through the Provider Web Portal. The Department's policy follows that of the Medicare program for hospitals paid through prospective payment."

- "The POA indicator is used to identify claims with Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). Specific codes associated with HCAC and OPPC are provided below. These are events which, if occurred while in the hospital (POA = N or U), can complicate care and member outcomes. Because these events can be deemed preventable, the Centers for Medicare & Medicaid Services (CMS)

does not allow the Department to pay additional costs of a higher All-Patient Refined Diagnosis Related Group (APR-DRG) assignment arising from HCACs or must deny payment altogether for OPPCs."

- "Hospital Acquired Conditions (HAC)/Healthcare-Acquired conditions (HCAC) – Refer to the latest CMS Medicare HAC List for the latest ICD-10-CM Diagnosis Codes."

Code of Colorado Regulation,10 CCR 2505-10 8.300.5

"2. Base Payment and Outlier Payment

DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment."

Code of Colorado Regulation,10 CCR 2505-10 8.300.12A

"4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to: d. Payment reviews; e. DRG validations;"

Code of Colorado Regulation,10 CCR 2505-10 8.076.3.A

"Overpayments are subject to recovery by the Department or its designees."

Code of Colorado Regulation,10 CCR 2505-10 8.076.3.B

"Any identified Overpayment shall be recoverable from the Provider following exhaustion of any informal reconsideration and appeal pursuant to 8.050."