Reimbursement policies are intended to supplement certain standard benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document always supersedes the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy.

Facility DRG Review

Policy Number: MAR46

Version 1.0

Annual Review Date: July 1, 2025

Plan Effective Date: Jan. 1, 2026

Description

Diagnosis-Related Groups are a patient classification system used to categorize inpatient hospital services for patients. HealthSpring utilize the Medicare Severity Diagnosis-Related Group payment methodology developed by CMS to reimburse for inpatient services provided to Medicare beneficiaries. According to the CMS MS-DRG definitions manual, DRG assignments reflect the patient's clinical condition, procedures performed, comorbidities/complications, and resource intensity.

This policy outlines the review process and documentation standards used to validate DRG assignments on facility claims submitted on the UB-04 (or its equivalent) format. Medical documentation at the time of service is the primary source of validation.

Definitions Table

Term	Definitions
MS-DRG (Medicare Severity Diagnosis Related Group)	A CMS-developed payment classification system that categorizes inpatient stays based on diagnoses, procedures, severity of illness, and resources intensity.
DRG Validation	A clinical and coding review process to ensure the DRG assigned is supported by the documentation in the patient's medical record.
Pre-Payment (Prospective Review)	A review conducted before the claim is paid to validate DRG accuracy using submitted clinical documentation.
Post-Payment (Retrospective Review)	A review conducted after the claim is paid to validate DRG accuracy using submitted clinical documentation to confirm the billed DRG is supported by medical records; it may result in adjustments or recoupments.
CC/MCC (Complication or Comorbidity/Major Complication or Comorbidity)	Secondary diagnoses that increase the severity level of a DRG and influence payment.
UHDDS (Uniform Hospital Discharge Data Set)	A standardized CMS data set required for inpatient discharge reporting used to assign DRGs.
POA (Present on Admission)	An indicator that shows whether a diagnosis was present at the time of hospital admission.
CMS	Centers for Medicare & Medicaid Services
ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification)	Used for diagnosis coding
ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System)	Used for inpatient procedure coding

Reimbursement Information

HealthSpring reimburses inpatient facility claims based on the DRG assigned according to CMS MS-DRG methodology and supported by the clinical documentation present in the medical record.

HealthSpring reserves the right to conduct both pre-payment (prospective) and post-payment (retrospective) DRG validation review. DRG assignments will be validated using clinical documentation available at the time of review and will be reviewed for coding accuracy, compliance with CMS grouping logic, and alignment with national coding guidelines.

All DRG claims are subject to review. Claims may be selected for pre-payment (prospective) or post-payment (retrospective) reviews.

Note: When conflicts arise between this policy and the provider's agreement or the Summary Plan Description, the contract or SPD takes precedence.

General Background

DRG validation is conducted in accordance with CMS guidelines, including the Medicare Program Integrity Manual (Chapter 6), ICD-10-CMS/ICD-10-PCS PCS Official Coding Guidelines, and the MS-DRG definitions manual. Medical records are reviewed to validate that coding reflects clinical documentation.

HealthSpring reviews medical records for the following DRG validation elements:

- Accurate and complete principal and secondary diagnosis coding per UHDDS and CMS guidelines
- Procedure coding consistency with ICD-10-PCS definitions
- Documentation of complications or comorbidities (CC/MCCs) that meet coding criteria
- DRG grouping alignment with Medicare Grouper pricing logic
- Present on Admission indicators accuracy
- Correct discharge disposition
- Justified length of stay based on documented clinical needs

Reimbursement will be made based on the following:

Pre-Payment Review

- Reimbursement will be based on the MS-DRG level supported by the medical documentation available at the time of review.
- If the submitted documentation does not support the billed DRG, the claim may be adjusted to validate DRG prior to payment.
- Appeal rights will be provided when appropriate.

Post-Payment Review

- Paid claims are subject to retrospective review for DRG validation to ensure compliance with Medicare rules, coding guidelines, and clinical documentation standards.
- If an error in the DRG assignment is identified during post-pay review, the claim may be adjusted or recouped consistent with CMS guidelines.
- Reopenings for DRG validation will follow CMS regulations under 42 CFR §405.980, which allow reopening within
    - **1 year for any reason;**
    - **4 years for good cause.**
    - **At any time** if there is evidence of fraud or similar fault.
- Providers will be notified of adjustments, rationale as well as specific reason for the reopening/revision of the claim, and appeal rights in accordance with federal requirements.

References

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Policy Update History

Approval Date	Description
01/01/2026	New policy