PROVIDER REIMBURSEMENT GUIDANCE			
DRG Validation			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
	04/01/2022	04/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

Payment Policy Summary

Commonwealth Care Alliance® (CCA) and/or the appropriate designee periodically reviews claim submissions against the member's medical records and other documentation to ensure the claim accurately represents the services billed. Claims are then compared against regulatory and coding guidelines as well as CCA policy. Inpatient facility claims which are reimbursed via DRG methodology will be reviewed for appropriateness of coding, grouping, length of stay and billed charges. Audits may be conducted either pre-payment or retrospectively.

Authorization Requirements

N/A

Definitions:

Diagnostic Related Group (DRG) any of the payment categories that are used to classify patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred

DRG Validation Audit: A process to verify DRG assignment and payment accuracy. This involves validating that inpatient services are physician-ordered, and/or determining whether coding on a claim and other factors that impact the DRG and claim payment are supported by medical record documentation and assigned in accordance with industry coding standards as outlined by the Official Coding Guidelines, the applicable ICD Coding Manual, and/or Coding Clinics.

Reimbursement Guidelines:

- The scope of these DRG audits includes validation of:
- Physician ordered inpatient status
- Accuracy of diagnostic code assignment
- Procedural code accuracy
- Appropriate sequencing of principal diagnosis code
- POA indicator assignment
- Accuracy of DRG assignment
- Discharge position
- Readmission
- Compliance with all CCA policy

Billing and Coding Guidelines:

Unless otherwise stated, CCA follows AMA, CMS, and ICD-10 coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, and their usage.

CCA will not accept retrospectively amended medical records or physician queries beyond 30 calendar days from the service date. CCA considers medical record documentation and/or physician queries present in the chart at the time the audit notification is made to the provider as the official record to support services provided for the basis of coverage or reimbursement determination.

Audit and Disclaimer Information

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

References

American Medical Association, Current Procedural Terminology (CPT®)

Centers for Medicare and Medicaid Services, CMS Manual System

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

Policy Timeline Details

1. Drafted January 2022
2. Approved: February 2022
3. Implemented: April 2022