![hms®]

DRG Validation Review

Get the support you need to for bill coding and diagnosis substantiation.

Proper coding of all diagnoses and procedure codes, as well as accurate and complete recording of all data elements that affect the diagnosis-related grouping (DRG) assignment, is critical to ensuring that a hospital is properly reimbursed.

DRG is a system to classify hospital stays into groups. Each group contains clinically similar patients, and therefore are expected to require the same hospital resources. DRGs are assigned by a "grouper" program based on diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities. DRGs are standard practice for establishing reimbursements for many acute care hospitals and the DRG payment represents an average cost for patients having similar diagnoses.

HMS uses time-tested algorithms to target claims with the highest potential for findings.

There is a high risk of DRG errors resulting from simple coding errors, and from providers attempting to increase the reimbursement by coding diseases that the patient did not have or that the attending physician had not attested to, changing the order of the codes, choosing a principal diagnosis other than the condition responsible for admission to the hospital, or picking a non- specific diagnosis.

Experienced coders or clinical staff with knowledge of coding guidelines perform a DRG validation review to ensure claims were billed in accordance with coding guidelines, and diagnoses were supported by documentation in the medical record.

As part of the DRG validation review, coding or clinical staff also perform a review of those conditions identified as hospital acquired conditions (HACs). An HAC is a medical condition or complication that a patient develops during a hospital stay, and therefore was not present on admission (POA).

Because these conditions can usually be prevented through quality care, the Centers for Medicare and Medicaid Services and most other payers now require providers to identify these conditions when billing, by way of the POA indicator.

When the POA indicator indicates the condition was not present on admission, the claim is processed as that diagnosis is not present, which may result in a lower payment based on a lower-paying DRG assignment.

HMS® employs a highly successful claims targeting approach, which targets claims that may have DRG errors resulting in inappropriate payments. HMS uses time-tested algorithms—built and refined over many years—to target claims with the highest potential for findings, which means we only request medical records when there's a likely improper payment. This process results in a high rate of findings, while minimizing provider abrasion that would otherwise result from requesting records inappropriately.

The purpose of the DRG validation review is to:

- Validate the principal and secondary diagnoses to ensure all diagnoses were billed appropriately, supported in the medical record, and billed according to official coding guidelines;

- Validate all procedure codes to ensure they were coded accurately according to official coding guidelines, and are supported by the documentation in the medical record;

- Verify the discharge status code and all other data elements affecting the DRG assignment; and

- Verify diagnoses identified as HAC's were coded with the correct POA indicator.

Features

- Pre- and post-payment approaches

- No member liability associated with findings

- Performed across all lines of business with DRG reimbursement methodology: Commercial, Medicare Advantage and Managed Medicaid health plans

- Full support for rebuttals and appeals

HMS has a finding rate of 18% for DRG validation reviews, saving an average of $3,780 per claim.

Contact HMS today to get started on your Inpatient DRG Validation Review.