KAISER PERMANENTE®
PAYMENT POLICY

DIAGNOSIS RELATED GROUP (DRG) Payment and Review

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☒ Medicare

☐ Medicaid

Policy

Original Effective Date: 01/01/2021

This policy provides information on rules that govern processes related to determining payment for claims under review. Kaiser Permanente (KP) is responsible for reviewing claims to ensure that providers comply with billing and coding standards, that services rendered are appropriate and medically necessary, and that payment is made in accordance with applicable contract and/or provider manual requirements.

When benefits allow, Kaiser Permanente may perform DRG reviews on claims which are reimbursed by MS-DRG, AP-DRG, and APR-DRG to validate that the diagnosis and procedural information leading to the DRG assignment is supported by the medical record.

The purpose of DRG validation is to ensure diagnostic and procedural information and 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 records.

Validation must ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim and matches both the attending physician's description and the information contained in the beneficiary's medical record.

Reviewers will validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

The comprehensive review of the patient's medical records will be conducted to validate:

- Physician-ordered inpatient status
- Accuracy of diagnostic code assignment
- Accuracy of the procedural code assignments
- Accuracy of the sequencing of the principal diagnosis and procedure codes
- Accuracy of present-on-admission (POA) indicator assignment
- Accuracy of DRG grouping assignment and associated payment
- Accuracy of Discharge Disposition Status Code assignment
- Other factors that may impact DRG assignment and/or claim payment

- Compliance with KP's payment policies including but not limited to those policies that address DRG inpatient facility, never events, hospital-acquired conditions, and readmissions or transfers to another acute care hospital

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Policy Definitions

Diagnosis Related Group (DRG): A system of classifying or categorizing inpatient stays into relatively homogenous groups for the purpose of payment

AP-DRG: Expansion of the basic DRGs to be more representative of non-Medicare populations, such as pediatric patients

APR-DRG: expansion of basic DRGs more representative of non-Medicare populations

MS-DRG: Medicare severity diagnosis group for classifying Medicare patients' hospital stay into various groups

POA: Present on Admission indicator documents whether condition was present at the time the admission occurs

Prerequisite(s)

Not applicable

References

Medicare Program Integrity Manual, Chapter 6- Medicare Contractor Medical Review Guidelines for Specific Services, §6.5.3- DRG Validation Review

https://www.cms.gov/medicare/icd-10/2021-icd-10-cm

https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

https://apps.3mhis.com/docs/Groupers/All_Patient_Refined_DRG/Methodology_overview_GRP041/grp041_aprdrg_meth_overview.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS

Frequently Asked Questions

Not applicable

Revision History

01/08/2024 – Annual review

08/15/2022 – Updated to fix broken links and change document formatting.

10/16/2020 – Reference Section Updated.

09/24/2020 – New Policy effective 1/1/2021

Note: This information is intended to serve only as a general reference resource regarding reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to our enrollees as legislative mandates, the provider contracts, the enrollee's benefit coverage documents, and the Provider Manual all may supplement or in some cases supersede this policy. This policy may be modified from time to time by publishing a new version of the policy on Kaiser Permanente provider website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.