Reimbursement Policy	
Subject: **Diagnosis Used in DRG Computation**	
Policy Number: **G-12005**	Policy Section: **Coding**
Last Approval Date: **03/15/2023**	Effective Date: **10/08/2020**

**** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ca**. ****

Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross (Anthem) if the service is covered by Medi-Cal Managed Care. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to our provider site.

Policy

Anthem ensures that the diagnosis and procedure codes that generate the Diagnosis Related Groups (DRG) are accurate, valid, and sequenced in accordance with national coding standards and specified guidelines unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

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Anthem performs DRG audits to determine that the diagnostic and procedural information that led to the DRG assignment is substantiated by the medical record. The audits utilize coding criteria to limit the billed diagnosis used in DRG computation to the following: those that are relevant to the patient's care; those that impact the patient's outcome, treatment, intensity of service or length of stay; and those that are supported by documentation within the medical record.

Anthem routinely monitors DRG billing patterns to ensure that hospitals perform fair and equitable coding and utilization.

Related Coding

Standard correct coding applies

Policy History

03/15/2023	Review approved: Policy template updated
10/08/2020	Review approved: Related policies updated
11/16/2018	Review: policy template updated
07/19/2017	Initial approval 07/19/17 and effective 10/05/17

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- California Department of Health Care Services Policies
- Anthem contract with the California Department of Health Care Services

Definitions

Diagnosis Related Groups (DRGs)	Diagnosis Related Groups (DRGs) are a patient classification method which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital.
General Reimbursement Policy Definitions	

Related Policies and Materials

Documentation Standards for an Episode of Care
Provider Preventable Conditions