Payment Policy: Optum CPI DRG Analytics

Reference Number: WC.PP.166
Product Types: All
Last Review Date: 7/2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The purpose of this policy is to achieve cost avoidance for the Health Plan by administering vendor-driven DRG coding rules and predictive score modeling analytics.

Application
This policy applies only to inpatient claim payments. These payments are based upon Diagnosis Related Groups (DRG) which are assigned to the patient upon hospital discharge.

Policy Description
According to CMS policy, Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.
Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d) (4) (C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

Currently, cases are classified into Medicare Severity Diagnosis Related Groups (MS-DRGs) for payment under the IPPS based on the following information reported by the hospital: the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay. In a small number of MS-DRGs, classification is also based on the age, sex, and discharge status of the patient. Effective October 1, 2015, the diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS).

Reimbursement
The Health Plan has enhanced its adjudication process and extends claim adjudication to also include an analysis of the claim as a whole and/or individual detail for the specific charges in comparison with the medical records. Through our vendor claims editing software program, the Health Plan may apply DRG rules to assist in determining proper coding for Provider claims

payment, whereby a DRG claim may have been submitted with an error and that error would lead to a higher ranged DRG leading to increase reimbursement.

Documentation Requirements
Once a claim has been identified for additional review, a denial will be assigned to the claim asking the provider to send medical record documentation support. If the provider does not provide the necessary documentation, the Health Plan will apply a technical denial to the claim.

Definitions
Diagnosis Related Group (DRG) - A diagnosis-related group (DRG) is a patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives. In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge. The DRG includes any services performed by an outside provider. Claims for the inpatient stay are submitted and processed for payment only upon discharge.

Additional Information
NA

Related Documents or Resources
- WC.PP.102: Pre-Payment and Post-Payment Review
- WC.PP.136: Comprehensive Payment Integrity (CPI)

References

1. Centers for Medicare & Medicaid Services. *MS-DRG Classifications and Software. Retrieved on July, 9, 2021 from* *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software*
2. Department of Health & Human Services: Centers for Medicare & Medicaid (CMS), CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 10654, Change Request 11895. Retrieved on July 9, 2021 from https://www.cms.gov/files/document/r10654cp.pdf

Revision History	
7/7/2021	Initial Policy Draft

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.