	Reimbursement Policy	
Subject: Diagnoses Used in DRG Computation		
Effective Date: **04/15/13**	Committee Approval Obtained: **10/08/20**	Section: **Coding**

*****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.healthybluela.com**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana benefit plan. 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, Healthy Blue may:

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

Healthy Blue 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Healthy Blue strives to minimize these variations.

Healthy Blue 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 this site.

Policy	Healthy Blue 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. Healthy Blue 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 those that: • Are relevant to the patient's care. • Impact the patient's outcome, treatment, intensity of service or length of stay. • Are supported by documentation within the medical record. Healthy Blue routinely monitors DRG billing patterns to ensure that hospitals perform fair and equitable coding and utilization. **Note**: This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.
History	• Biennial review approved **10/08/20**: related policies updated • Biennial review approved **11/16/18**: policy template updated • Effective **09/01/17**: policy template updated • Biennial review approved **10/03/16**: policy template updated • Biennial review approved **08/18/14**: policy language updated • Review approved **09/09/13** with effective date **04/15/13**: disclaimer updated • Initial review approved **07/16/12** and effective **04/15/13**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • American Medical Association
Definitions	• **Diagnosis Related Groups (DRGs)**: 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	• Documentation Standards for an Episode of Care • Preventable Adverse Events
Related Materials	• None