Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Diagnoses Used in DRG Computation

Effective Date:	Committee Approval Obtained:	Section:
01/01/15	**10/08/20**	**Coding**

*****The most current version of the 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.amerigroup.com.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Amerigroup Medicare Advantage 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	Amerigroup Medicare Advantage ensures that the diagnosis and procedure codes that generate the diagnosis-related groups (DRGs) 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. Amerigroup Medicare Advantage 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. Amerigroup Medicare Advantage routinely monitors DRG billing patterns to ensure that hospitals perform fair and equitable coding and utilization.
History	• Biennial review approved 10/08/20: related policies updated • Biennial review approved 11/16/18: policy template updated • Biennial review approved 10/03/16: policy template updated • Initial approval effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • American Medical Association
Definitions	• **Diagnosis-Related Groups (DRGs)**: used to indicate that a subsequent procedure was performed during the postoperative period of the original surgical procedure; the subsequent procedure must be related to the original procedure and must require a return trip to the operating or procedure room • **General Reimbursement Policy Definitions**
Related Policies	• Documentation Standards for an Episode of Care • Preventable Adverse Events
Related Materials	• None