DRG Validation Review

Educating providers on our clinical validation review concept

HMS has been contracted by a health plan client to conduct diagnosis-related group (DRG) Validation Reviews. Proper coding of all diagnoses and procedure codes, as well as accurate and complete recording of all data elements that affect the DRG assignment as documented in the medical record, is critical to ensuring that a hospital is properly reimbursed.

HMS reviews targeted DRG claims to verify that all diagnoses and procedure codes were billed appropriately in accordance with official coding guidelines and were consistent with the documentation in the medical record resulting in accurate DRG assignment and reimbursement. This review will validate all data elements that affect the DRG assignment, including accurate billing of present on admission indicators.

Coding validation is the process of verifying that codes were billed and sequenced in accordance with coding guidelines. Clinical validation is an additional process, and is performed in addition to the coding validation review. Clinical validation verifies that the diagnoses coded were actually present based on the clinical documentation in the medical record, and the results of related diagnostic testing were consistent with the diagnoses. In cases in which there is a conflict between the diagnosis coded, and the associated clinical indicators for that condition, the diagnosis will be removed from the grouping which may result in assignment of a DRG that more appropriately reflects the medical documentation.

The purpose of the DRG validation review is to:

- Validate the principal and secondary diagnoses to ensure all diagnoses were billed appropriately, supported in the medical record, and billed according to official coding guidelines;
- Validate that the clinical documentation and results of diagnostic testing support the billed diagnosis;
- Validate all procedure codes to ensure they were coded accurately according to official coding guidelines, and are supported by the documentation in the medical record;
- Verify the discharge status code and all other data elements affecting the DRG assignment; and
- Verify diagnoses identified as HAC's were coded with the correct POA indicator.

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Guidelines and Review Criteria

HMS uses national coding guidelines as well as industry standard criteria and definitions to substantiate the billed diagnoses codes affecting DRG assignment. Clinical validation verifies that diagnoses documented in a patient's medical record are substantiated by criteria that are generally accepted by the medical community. These criteria typically come from professional guidelines and other evidence-based sources. For example, HMS uses the Third International Consensus Definition (better known as Sepsis-3) criteria for Sepsis and Septic Shock which is the standard currently being used in the medical community. Sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection. For clinical operationalization, organ dysfunction is represented by an increase in the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score of 2 points or more, which is associated with an in-hospital mortality greater than 10%. Substantiation of this criteria in the medical record would be necessary to clinically validate the diagnosis of sepsis.

What to Expect During the Audit Process

Claim audits are an important tool health plans use to control cost and ensure compliance with regulations and policies. When submitted claims are selected for DRG Validation review, you will receive a medical record request letter regarding medical records relevant to the claims in question.

The medical record request will include:

- Additional information on the audit being performed;
- List of medical record documentation needed in order to complete the audit;
- A time frame explaining when the medical record must be received and;
- Instructions on the best way to submit medical record documentation to HMS.

The medical record request letter also will include contact information for our Provider Relations team, who are ready to answer any question and help with the audit process.

After the requested medical records are received, an experienced team of coders, nurses or physicians will perform an in-depth review of the submitted documentation. The type of audit HMS conducts on any group of claims can vary and is determined by the criteria set by the health plan.

Based on our findings, a determination is made, and a notice is mailed informing you of the results. If the notice is for an overpayment, we'll provide the claim information and the rationale for the determination. It's possible you may disagree with the audit findings and rationale. If that is the case, detailed instructions for appealing the determination are included.

Contact HMS today for additional questions regarding our Clinical Claims Review process or if you have questions regarding a request for medical records you received.

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