Overview

A diagnosis-related group (DRG) is a patient classification system that standardizes reimbursement to hospitals and encourages cost containment initiatives.

Reimbursement for inpatient hospitalizations for many Cigna participating facilities is made based on the Diagnosis Related Group (DRG) methodology. Under a typical DRG reimbursement arrangement, the hospital is paid a flat rate regardless of the number of days hospitalized and includes all charges associated with the inpatient stay.

This policy applies to UB-04 claim forms and electronic counterparts.

Reimbursement Policy

Cigna reimburses hospital/facility services consistent with the provider agreement, the customer’s benefit plan, and Cigna coverage, reimbursement and utilization review guidelines and criteria.

This policy applies to inpatient claims for hospital admissions paid based on DRG (Diagnosis Related Group) payment methodology, including:

- MS-DRG,
- CMS-DRG,
- AP-DRG, and
- APR-DRG.

Effective 8/15/11, Cigna will request and review medical records to determine the appropriateness and substantiate the accuracy of hospital coding to ensure that the DRG is a true reflection of the clinical services provided. Such reviews may be performed pre-payment or post-payment.

Following review, reimbursement will be made:
Based on original billing if appropriate, or
At the DRG level represented by medical documentation.
Appeal rights will be provided when appropriate.

General Background

Reimbursement for inpatient hospitalizations for many Cigna participating facilities is made based on the Diagnosis Related Group (DRG) methodology. Under a typical DRG reimbursement arrangement, the hospital is paid a flat rate regardless of the number of days hospitalized.

DRG’s methodologies:
- Medicare Severity DRG (MS-DRG)
- Centers for Medicare and Medicaid Systems DRG (CMS-DRG)
- All-Patient DRG (AP-DRG)
- All Patient Refined DRG (APR-DRG)

Cigna is implementing a data-sharing and case review program to work with our DRG contracted hospitals to ensure that coding and payment reflect, as accurately as possible, the resources used to care for the patient.

How Cigna will compare DRG Billing Patterns and identify outliers

- Hospitals are grouped into three categories for comparison:
  - Large hospitals with a high ratio of resident physicians, consistent with teaching centers.
  - Large and medium sized hospitals with a lower ratio of residents to attending physicians.
  - All other hospitals reimbursed using a DRG payment methodology.
- MS-DRG v 28 is utilized to calculate the DRG for all hospitals to normalize billing data
- For each tier, and for each Major Diagnostic Category (MDC), the average Relative Weight (RW) is calculated. Outliers are identified by comparing MDC weights to their peers in each category. Outliers are those identified as having a significantly higher RW average over the same time period compared to similar institutions.

Review Program

- Medical records will be requested prior to payment* when it is determined a claim will be reviewed.
- Appropriate certified and/or licensed staff will review the claim once records are received.
- Procedures and/or diagnoses not substantiated in the medical records and codes improperly or inaccurately listed will be deleted from the claim. The DRG will be derived from the remaining codes as well as any substitutions the reviewers have determined to be more accurate. Principles for code reporting will, for the most part, follow CMS rules for CMS Recovery Audit Contractor (RAC) audits.
- When medical records are requested and not received within the established time frame, the result is the denial of the claim. Appeal rights will be provided when appropriate.

*Reviews may be performed post-payment where state regulations or contractual provisions prevent review pre-payment.

References

2. HCPCS, Health Care Procedure Coding System, National Level II Medicare Codes, Copyright© 2017 Practice Management Information Corporation (PMIC).


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