DRG Assignment and Reimbursement Disputes

Reimbursement Policy ID: RPC.0147.PA02

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes the plan's approach to the review and resolution of facility-submitted Diagnosis-Related Group (DRG) assignment and reimbursement disputes. DRG assignment is dependent on the claim information submitted by the facility, including the principal diagnosis, secondary diagnoses, procedures performed, discharge status, patient-specific information, claim frequency, and the applicable grouper methodology. Discrepancies may occur when the submitted claim data, coding, documentation, claim frequency, or grouper version results in a DRG assignment or relative weight that differs from the facility's

expected reimbursement. This policy is intended to promote consistent review of DRG-related disputes, identify common causes of DRG assignment discrepancies, and clarify circumstances that may affect DRG recalculation, claim adjustment, or reimbursement determination.

Exceptions

This policy excludes pre-payment and post-payment DRG validation reviews initiated by the plan.

Reimbursement Guidelines

DRG Assignment
The Health Plan will assign the DRG based on:

- Information submitted on the claim.
- Applicable Medicare grouper methodology.
- Coding established by:
    - Centers for Medicare & Medicaid Services (CMS).
    - ICD-10-CM and ICD-10-PCS Official Coding Guidelines.
    - National Uniform Billing Committee (NUBC) standards.

Claims may be regrouped if submitted information results in a different DRG assignment than expected by the provider.

Discrepancies in DRG assignment or reimbursement may result from several claim submissions, coding, documentation, or system-related factors, including but not limited to the following:

- The plan's grouper version or methodology may differ from the version used by the facility, which may result in a different DRG assignment or relative weight.
- A corrected claim does not include the appropriate original claim identifier, preventing the plan from accurately matching the corrected submission to the previously processed claim.
- The facility did not submit all applicable diagnosis, procedure, or other required claim codes needed to support the requested DRG assignment.
- Multiple corrected claims for the same member and date of service are submitted on the same day, which may cause one or more submissions to be identified as duplicate claims and prevent processing.
- The claim frequency code submitted through the 837 transaction does not accurately identify the claim as an original, replacement, or voided claim. Corrected claims should be submitted with frequency code 7, and voided claims should be submitted with frequency code 8. Submissions with frequency code 1 may be treated as original claims and denied as duplicates when a prior claim has already been processed.
- If a Health Care-Acquired Condition (HCAC) or Hospital-Acquired Condition (HAC) diagnosis is reported on the claim and is not present on admission, the diagnosis may be excluded from the DRG calculation for payment purposes
- The newborn's birth weight is not reported with the applicable diagnosis code. When birth weight information is required for DRG assignment and is not submitted, the plan may calculate the DRG using a default normal newborn weight (2500 grams), which may affect reimbursement, which may result in assignment to a lower-weight DRG and reduced reimbursement.

For Medicare-based reimbursement arrangements, reimbursement will be determined using the applicable CMS MS-DRG grouper version and payment rules in effect for the discharge date, unless otherwise specified by contract.

The facility should review the reasons for the discrepancy and determine whether corrective action is needed, including submission of a corrected claim or additional supporting documentation when applicable.

Definitions

Grouper
Software that assigns a DRG based on submitted claim and clinical information.

HIPAA-Compliant 837 File
An 837 file is a HIPAA-compliant ASC X12 electronic transaction used by health care providers to submit medical claims to insurance payers.

Hospital Acquired Conditions
Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

MS-DRG
Medicare Severity Diagnosis Related Group methodology used by CMS to classify inpatient hospital services for reimbursement purposes.

Edit Sources

I. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
II. Healthcare Common Procedure Coding System (HCPCS).
III. Centers for Medicare and Medicaid Services (CMS).
IV. National Uniform Billing Committee.
V. Applicable health plan provider manual.

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	Reimbursement Policy Committee Approval