PCHP Reimbursement Policy		
Topic: Inpatient DRG Diagnosis Codes	Policy Number: PCHP.RI.008	Policy Section: Administration
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

PCHP ensures the accuracy, validity, and proper sequencing of diagnosis and procedure codes that determine Diagnosis Related Groups (DRG), following national coding standards and specified guidelines unless otherwise specified by provider, state, federal, or CMS contracts or requirements. PCHP does not accept the billed DRG on a claim and recalculates all DRGs using the billed diagnosis codes in the submitted claim.

PCHP conducts DRG audits to verify that the diagnostic and procedural information leading to DRG assignment is supported by the medical record. These audits apply coding criteria to restrict billed diagnoses used in DRG calculation to those pertinent to patient care, impacting outcomes, treatment, service intensity, or length of stay, and supported by documented medical record evidence.

PCHP regularly monitors DRG billing patterns to ensure hospitals maintain fair and equitable coding and utilization practices.

References:

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative.

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025