Reimbursement Policy

Title: DRG Validation	
Policy Number: RP05	**Applies to:** ☒ Commercial
Effective Date: 12/1/2025	☒ Level Funded
Last Updated:	☒ Medicare Advantage ☐ Medicaid

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines, including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities unless a specific exception is stated in the policy.

If proper coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

DRG: Diagnostic-related group. DRG is based on the patient's primary and secondary diagnoses, other conditions (comorbidities), age, sex, and necessary medical procedures.

Policy

This reimbursement policy applies to both pre-payment and post-payment CMS-1450 (UB-04) claim forms (or their electronic equivalent), to ensure accurate hospital DRG reimbursement. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions.

Quartz Health Insurance, or its designated review entity, conducts DRG clinical validation reviews on both a pre-payment and post-payment basis. These reviews confirm that the DRG assigned by the facility accurately reflects the services documented in the member's medical record and that reimbursement complies with federal and state regulations, industry standards, contract terms, and Quartz policies. At any time, a request may be made for medical records, and/or itemized bills related to claims for the purpose of conducting audits or reviews.

Correct DRG assignment is evaluated in accordance with recognized industry coding standards, including guidance from:

- Official ICD-10-CM/PCS Coding Guidelines
- Official ICD Coding Guidelines
- Uniform Hospital Discharge Data Set (UHDDS) definitions
- AHA Coding Clinic publications

The assigned DRG and principal diagnosis must reflect the condition that is clinically established as the primary reason for the member's admission. DRG validation determinations are based on the medical record documentation available at the time of review and must support all reported diagnoses and procedures, including Major Complications or Comorbidities (MCCs), Complications or Comorbidities (CCs), and any elements related to severity of illness.

DRG clinical validation may include, but is not limited to, verification of:

- Diagnostic code assignments
- Procedure code assignments
- Code sequencing
- DRG grouping and associated payment
- MCCs, CCs, and severity level validation (as applicable)

If DRG clinical validation does not support the billed DRG assignment or identifies inconsistencies with industry coding standards, Quartz Health Insurance may take one or more of the following actions:

- Reassign the DRG to one supported by the medical record
- Adjust the payment amount
- Request a refund or initiate recoupment of overpaid funds
- Issue payment at the base DRG level when supporting documentation is insufficient
- Deny the claim

Related Policies

General Coding Guidelines

Resources

Centers for Medicare and Medicaid Services (CMS)
Official UB-04 Data Specifications Manual

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

Document History

12/1/2025	Document created	Payment Integrity Department