DRG 056: Degenerative Nervous System Disorders with MCC, DRG 057: Degenerative Nervous System Disorders without MCC Checklist

Diagnosis Related Group (DRG) Coding Checklist MS-DRG Description Adjustment Factor 056 (Degenerative nervous system disorders w MCC) / 057 Degenerative nervous system disorders w / o MCC	**Yes**	**No**	**N / A**
On inpatient claims providers must report the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a Medicare Severity - Diagnosis Related Group (MS-DRG) and an incorrect payment to a hospital under PPS. See 100-04 Chapter 25, Completing and Processing the Form CMS-1450 Data Set, for instructions about completing the claim. Change Request 8692. (PDF) https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3081CP.pdf **Is there a principal diagnosis, all relevant diagnoses, and procedures documented on the claim and coded correctly?**			
Other diagnoses codes are required on inpatient claims and are used in determining the appropriate MS-DRG Change Request 8692. (PDF) https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3081CP.pdf **If the comorbid condition, complication, or secondary diagnosis affecting the DRG assignment is not listed on the hospital claim but is indicated in the medical record, is the appropriate code inserted on the claim form?**			
The provider reports the full codes for up to twenty-four additional conditions if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. Change Request 8692. (PDF) https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3081CP.pdf **If the hospital already reported the maximum number of diagnoses allowed on the claim form, have you deleted the code that does not affect the DRG assignment and inserted a new code?**			

Diagnosis Related Group (DRG) Coding Checklist MS-DRG Description Adjustment Factor 056 (Degenerative nervous system disorders w MCC) / 057 Degenerative nervous system disorders w / o MCC	**Yes**	**No**	**N / A**
Is the principal diagnosis coded to the highest level of specificity? Medicare Claims Processing Manual (PDF) https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf Verify that the medical record is in accordance with and coding supports Social Security Act 1861 (r)(1), 1861 (aa) (5) and (bb) (2)m 21.			
The Admitting Diagnosis Code is required for **inpatient hospital** claims subject to contractor review. The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. For **outpatient** bills, the field defined as Patient's Reason for Visit is not required by Medicare but may be used by providers for nonscheduled visits for outpatient bills. Diagnosis codes must be reported based on the date of service (including, when applicable, the date of discharge) on the claim and not the date the claim is prepared or received. **Does the diagnosis relate to the current hospital stay and not to an earlier episode?**			
Documentation supporting medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request Change Request 8692. (PDF) https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3081CP.pdf **Does the documentation support the medical necessity of all diagnosis and procedure codes billed on the claim?**			
Is there documentation for the billed date of service? Verify that the medical record is in accordance with and coding supports 42 CFR 410.69, 410.74, 410.75, 410.76, 410.77, 482.25, 482.52			
Is there documentation of the intent to provide services on an inpatient basis? Reference Comprehensive Error Rate Testing (CERT): Part A Checklist (PDF) https://www.palmettogba.com/palmetto/providers.nsf/files/Part_A_CERT_Checklist_01212022.pdf/$FILE/Part_A_CERT_Checklist_01212022.pdf			

Diagnosis Related Group (DRG) Coding Checklist MS-DRG Description Adjustment Factor 056 (Degenerative nervous system disorders w MCC) / 057 Degenerative nervous system disorders w / o MCC	**Yes**	**No**	**N / A**
Medicare requires that services provided/ordered be authenticated by the author. The signature for each entry must be legible and should include the practitioner's first and last name. For clarification purposes, we recommend you include your applicable credentials (e.g., P.A., D.O. or M.D.). **Have you adhered to all signature requirements?** Medicare Program Integrity Manual (PDF) https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf			
Was the admission and the procedure medically necessary but the procedure could have been performed on an outpatient basis? (Validate that the coding is appropriate for the level and type of service noted in the medical record requirements as defined in the Program Integrity Manual (PIM) (IOM Pub. 100-08) and/or the Claims Processing Manual (CPM) (IOM Pub. 100-04), as applicable.			
Has there been a delay in discharge? If so, then the case, can potentially be reviewed for length of stay. (Please refer to CMS Internet-Only Manual Medicare Program Integrity Manual 100-08 Chapter 6 Section 6.5.6.)			
There has been a change in the DRG following the review and validation period which is now resubmitted in accordance with the Official Guidelines for Coding and Reporting? ICD-10-CM Guidelines April 1, 2023, FY23 (PDF) https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf			