DRG Validation of Inpatient Hospitals Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to inpatient hospitals (place of service 21) that render services to members of the CarePartners of Connecticut plans selected above. For information on readmission and bridging of claims, refer to the Readmission (Bridging of Claims) Policy.

In addition to the specific information contained in this policy, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary inpatient services, in accordance with the member's benefits.

CarePartners of Connecticut, either directly or via a designee, reviews claim submissions via medical records and other pertinent documentation to ensure that claims accurately represent the services provided to members, that billing is conducted in accordance with CMS guidelines and requirements and other applicable standards, rules, laws, regulations, contract provisions and payment policies, and that claims are compensated correctly. Payments made for claims found to be inconsistent with CarePartners of Connecticut policies and/or CMS guidelines and requirements may be earmarked for resolution (refer to the Second Request and Determination sections below for more information).

Audit Requests and Notification

Cotiviti Healthcare (on behalf of CarePartners of Connecticut) will notify the provider with its intent to audit. Notification will occur within the time frame indicated in the provider agreement, absent any indication of fraud. All requests for audits include the member's name, subscriber ID, date of birth, date of service and medical record or claim number, as well as the identity of the designee.

Cotiviti Healthcare conducts reviews of medical records for DRG validation and medical necessity on behalf of CarePartners of Connecticut. Providers must send medical records directly to Cotiviti. The sender should follow the minimum necessary precept (45 CFR 164.502(b), 164.514(d)) embedded in HIPAA's Privacy Rule.

Review Timeline

Initial Request

The provider must respond to the initial medical record request from Cotiviti Healthcare according to the time frame/limit indicated in the initial request.

Second Request

If the requested documentation is not received within the time frame specified in the initial request, Cotiviti will make a second request to the hospital/facility. Providers will have an additional period of time, as indicated in the second request letter, within which to submit documentation. If medical records are not received within this extended time frame (specified in the second request), payment for impacted claims will be retracted.

Documentation may not be reviewed if it is received beyond this time frame.

Delayed Time Frame

The submitted documentation must be completed and in order as indicated in the medical record request letter. Providers who cannot accommodate an audit request according to these guidelines or time frames must contact Cotiviti at 770-379-2165 or by email at icrsprovrel@cotiviti.com to explain why the request cannot be met and propose a reasonable date by which medical records and other documentation can be furnished. CarePartners of Connecticut will determine if the delayed time frame is acceptable and, if not, will work with the provider to resolve any issues associated with production.

Review of Medical Claims

Upon Cotiviti's review of the claims and supporting medical record documentation, if an underpayment or overpayment is uncovered, no change determination will be rendered if the anticipated amount of the underpayment or overpayment is less than $1 or $10 respectively. However, an adjustment can be implemented manually if the underpayment is less than $1.

Determination

Cotiviti Healthcare will clearly document the rationale for the determination. This rationale will list the review findings including a citation of the policy or rule in question. Reviewers will ensure that pertinent facts contained in the medical record are identified to support the review determination. Each rationale must be specific to the individual claim under review.

- **No Change Determination**: Cotiviti's determination indicates that the medical record request and supporting documentation has appropriately substantiated the original services billed.
- **Change Determination:** Cotiviti's determination indicates that the medical record request and supporting documentation has not appropriately substantiated the original services billed.

If the provider agrees with the change determination, or does not appeal the change determination within the timeframe described below or as otherwise specified in the applicable provider contract, CarePartners of Connecticut will correct claims based on the DRG reassignment identified in Cotiviti's determination. The provider will not be required to submit a corrected claim. Contracting providers may not bill the member for any reimbursement differences that result from the audit.

First Level Appeals

If the provider disagrees with the determination of the claims review, an appeal must be filed within 60 calendar days from the date of the change determination letter. The appeal should be sent to Cotiviti and must include the following information:

- Rationale for disagreeing with the decision
- Contact information for the person at the hospital responsible for the appeal
- Whom the reviewer can contact for more information
- Citation and written description of any relevant rules, policies or conventions

The reviewer shall conduct a reopening of the case within 60 days of receipt of the appeal. The appeal will be assigned to either a certified R.N. or certified medical coder, depending on the type of appeal received. Upon completion of the review, the provider will receive an audit determination letter outlining the decision.

Second Level Appeals

If the provider disagrees with the first level appeal determination of the claims review, a second appeal must be filed within 60 calendar days from the date of the first appeal determination letter. The appeal should be sent to:

CarePartners of Connecticut
PO Box 9162
Watertown, MA 02471-9162

The appeal must include the following information:

- Rationale for disagreeing with the decision
- Contact information for the person at the hospital responsible for the appeal
- Whom the reviewer can contact for more information
- Citation and written description of any relevant rules, policies or conventions

The reviewer shall conduct a reopening of the case within 60 days of receipt of the appeal. The appeal will be assigned to either a certified R.N. or certified medical coder, depending on the type of appeal received. The reviewer will work with the CarePartners of Connecticut medical director, if necessary, to render a decision.

Definition

Bill: Any document that represents a provider's request for payment, also referred to as an invoice or a claim.

DRG Validation Audit: A process to verify DRG assignment and payment accuracy. This involves validating that inpatient services are physician-ordered, and/or determining whether coding on a claim and other factors that impact the DRG and claim payment are supported by medical record documentation and assigned in accordance with industry coding standards as outlined by the official coding guidelines, the applicable ICD Coding Manual and/or coding clinics.

Medical/Health Record: A compilation of data supporting and describing a patient's health care encounter including data on diagnoses, treatment and outcomes. This may also be referred to as medical record.

Additional Resources

- Skilled Nursing Facility Payment Policy
- Inpatient Facility Payment Policy
- Observation Facility Payment Policy

Document History

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- May 2019: Updated determination and appeals sections to reflect CarePartners of Connecticut adjustment of applicable claims based on Cotiviti's determination
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.