

## DRG Validation of Inpatient Hospitals Policy

Applies to the following Tufts Health Public Plans products:

- Tufts Health Direct – Health Connector
- Tufts Health RITogether – A RI Medicaid Plan
- Tufts Health Together – Includes MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health Unify – OneCare Plan

The following audit policy applies to Tufts Health Plan contracting inpatient hospitals that render services for Tufts Health Public Plans products. This policy establishes the basic framework for DRG Validation and Readmission Audit Program procedures, and establishes how Tufts Health Plan, the contracted audit agent, and the provider will conduct themselves during the audit process. This policy supersedes any and all provider audit policies for DRG.

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

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

### POLICY

Tufts Health Plan, 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 Tufts Health Plan policies and/or CMS guidelines and requirements may be earmarked for resolution.

### BACKGROUND

Audits within the DRG Validation and Readmission Audit Program compare coding data and the DRG assignment on a provider's claim against the clinical documentation and the criteria of Tufts Health Plan's [Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#), including readmission criteria. The focus of the audit is to validate the coding and DRG assignments and the accuracy of Tufts Health Plan payment, and to identify readmission flags.

It is the responsibility of both Tufts Health Plan and the provider to take steps to improve these coding and payment processes and, in return, more effectively manage increasing health care expenditures.

### AUDIT REQUESTS AND NOTIFICATION

Equian (on behalf of Tufts Health Plan) 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.

Equian conducts reviews of medical records for DRG validation and medical necessity on behalf of Tufts Health Plan. As indicated in Equian's request, providers must send medical records directly to Equian. The sender should follow HIPAA's minimum necessary requirements (45 CFR 164.502(b), 164.514(d), as may be amended from time to time).

### RESPONSIBILITY OF TUFTS HEALTH PLAN PROVIDERS

Tufts Health Plan and the provider involved in a DRG validation and/or DRG readmission audit are responsible for the conduct and results of such audits whether conducted by a direct employee or by a contracted audit agent. This requires that Tufts Health Plan and the provider should:

- Exercise proper supervision of the process to ensure that the billing audit is conducted according to the guidelines set forth in this policy.

- Be aware of the actions being undertaken by the auditor in connection with the billing audit and its related activities.
- Take prompt remedial action if inappropriate behavior by the auditor is discovered and/or reported to Tufts Health Plan or the provider.

### **GUIDELINES FOR DRG AUDITS**

These guidelines are for audits that relate to the verification of payment accuracy, validation of documentation, and support of coding submitted on a claim, and flagging of DRG readmissions. All timeframes listed below apply unless otherwise specified in the applicable provider contract.

#### **Definitions**

- **Audit Log:** A historical record that records the audit experience related to a particular provider.
- **Bill:** Any document that represents a provider's request for payment, also referred to as an invoice or a claim.
- **DRG Readmission Audit:** A process to determine whether a second DRG claim meets readmission criteria as defined in the [Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#).
- **DRG Readmission Flag:** Circumstances that may qualify a second DRG claim as a readmission subject to physician review, which may result in denial of one of the two admissions, based on the [Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#).
- **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.
- **Retrospective Audit:** A DRG audit conducted after the adjudication of the claim.
- **Health Record:** A compilation of data supporting and describing a patient's health care encounter including data on diagnoses, treatment and outcomes. May also be referred to as medical record.
- **Submission Date:** The date the initial audit results are submitted to the provider. This date is identified on the Preliminary Audit Report and is followed by a rebuttal period of 30 calendar days during which the provider may rebut the initial audit determination by submitting additional information directly to the contracted audit agent for review before a final audit determination is presented to Tufts Health Plan.
- **Final Audit Report Date:** The date the Final Audit Report is issued to the provider and Tufts Health Plan by the contracted audit agent. This date is identified in the Final Audit Report and is followed by an appeal period of 30 calendar days during which the provider may submit directly to Tufts Health Plan an appeal to have the contracted audit agent's final coding, DRG reassignment determination, and/or a DRG readmission flag reconsidered.

#### **Qualifications of Auditors and Provider Audit Coordinators**

All persons performing DRG audits, as well as persons functioning as DRG audit coordinators, should have appropriate knowledge, experience and/or expertise in a number of health care areas including, but not limited to, the following:

- Health record content and format, as well as other forms of health/clinical documentation
- Generally accepted auditing principles and practices as they may apply to billing audits
- Inpatient coding conventions and standards, included in the Official Coding Guidelines, the ICD Coding Manual, Coding Clinics, and medical terminology
- Billing claims forms, including the UB-04, as well as charging and billing procedures
- All state and federal regulations concerning the use, disclosure and confidentiality of all patient records including, but not limited to HIPAA

Auditors should be able to work with a variety of health care personnel. They should always conduct themselves in an acceptable, professional manner and adhere to ethical standards, including, but not limited to, the American Health Information Management Association Code of Ethics, confidentiality requirements and objectivity.

Auditors will not be placed in any situation through their remuneration, benefits, contingency fees or other instructions that would call their findings into question.

### **Notification and Scheduling of DRG Audits**

Tufts Health Plan or its contracted audit agent and provider audit personnel should make every effort to directly resolve audit and coding inquiries.

Audits begin with written or verbal notification to the provider of Tufts Health Plan's intent to audit. Such notification should occur no later than two years after receipt of the final claim submission.

Providers are expected to comply with Tufts Health Plan's policy regarding submission of late claims. For more information, refer to the Claims chapter of the [Tufts Health Public Plans Provider Manual](#).

All requests for audits should include the following information:

- Patient name, date of birth, date of service and medical record number
- Auditor name and audit firm name, if auditor is not a Tufts Health Plan employee

Tufts Health Plan or its contracted agent may conduct audits off-site. Provider is required to submit a complete medical record for each claim to be audited directly to the contracted audit agent, upon request. Audits will be grouped to increase efficiency whenever possible. Tufts Health Plan or contracted audit agent will pay no fees related to the audit itself, including copying fees for the medical record.

Providers shall submit a copy of the complete medical record to Tufts Health Plan's contracted audit agent within 30 days of the request date. Providers who cannot accommodate an audit request that conforms to these guidelines must present the rationale as to why the request cannot be met and propose a reasonable period of time within which medical record copy will be furnished. Tufts Health Plan will determine if the delayed time frame will be acceptable and, if not, will assist the contracted audit agent in negotiating a reasonable compromise. Providers may also choose to grant permissions to Tufts Health Plan or its contracted agents to access their EHR systems to more efficiently obtain medical record documentation. Furthermore, providers may choose to authorize third party record fulfillment vendors to comply with requests received from Tufts Health Plan or its contracted agents. In doing so, all other terms and conditions stated herein will continue to apply.

Tufts Health Plan expects that the health record presented at the time for audit will be complete and legible. A separate, signed patient authorization will not be needed to conduct the audit.

Providers should always strive to group audits to increase efficiency whenever possible. If a provider is unable to accommodate the grouping of audits for any reason, the provider agrees to cooperate with auditors who may opt to conduct the audits off-site.

If a provider believes an auditor may have problems accessing records, the provider shall notify the auditor no less than two weeks prior to the scheduled date of audit to reschedule such audit date within a 30-day period. Providers shall supply the auditor and Tufts Health Plan with any and all information that could affect the efficiency of the audit.

### **DRG Audit Coordinators**

Providers will designate an individual(s) to coordinate all DRG audit activities. Duties of a DRG audit coordinator include, but are not limited to, the following areas:

- Scheduling audits
- Advising other provider personnel/departments of pending audits

- Verifying that the auditor is an authorized representative of Tufts Health Plan
- Gathering the necessary documents for the audit and ensuring that the health record is complete and in order
- Coordinating the auditor's requests for information and ensuring that a complete copy of the medical record is submitted to requesting agent
- Orienting auditors to the provider's record documentation processes and electronic medical record system
- Acting as a liaison between the auditor and other provider personnel
- Participating in an exit interview with the auditor to answer questions and review audit findings
- Reviewing the auditor's determination, and following up on any audit findings still in question or dispute
- Arranging for any required adjustment(s) to the claim(s) or issuing refunds to Tufts Health Plan.

### **Conditions of DRG Audits**

In order to ensure a fair, efficient and effective audit process, providers and Tufts Health Plan's audit designees shall adhere to the following:

- All personnel involved in the audit shall maintain a professional courteous manner and resolve all misunderstandings amicably.
- The provider is expected to present a complete medical record, which includes documentation to support all ICD code assignments and the DRG.
- Audit findings will be submitted in writing to the provider at the completion of the initial audit by the auditor. The report will include the following, as applicable: revised ICD codes, revised DRG, and supporting rationale for the coding change(s), DRG reassignment. Readmission Flags will include a clinical summary of the readmission circumstances and rationale for Readmission Flag.
- DRG reassignment determinations will reference applicable Official Coding Guidelines, the ICD Coding Manual, Coding Clinics, and/or Tufts Health Plan's payment policies in support of coding and/or DRG reassignments.
- An exit interview will be offered to the provider representative by the auditor or contracted audit agent at the completion of the audit.
- The specific content of the final report will be made available to Tufts Health Plan and only those parties involved in the audit.
- Audit findings will be put in dispute when the provider and the contracted audit agent agree to disagree on the audit findings.

### **Disputed Audit Findings**

#### **Opportunity for provider to rebut audit findings:**

- DRG Validation Audits: Resolution of any discrepancies, questions or errors that have been identified in the audit shall occur within 30 calendar days of the Submission Date. All audit determinations will stand and the audit results deemed final if the provider fails to submit to the contracted audit agent a rebuttal accompanied by supporting documentation to refute the initial audit findings or to communicate agreement with the audit findings within 30 calendar days of the Submission Date.
- DRG Readmission Audits: Providers will be afforded an opportunity to rebut the audit findings within 30 calendar days of Submission Date. Provider rebuttals will be evaluated by a physician reviewer prior to taking action on the claim. If provider fails to submit a rebuttal and supporting documentation to the contracted audit agent within 30 calendar days of the Submission Date, initial audit findings will stand and the readmission claims will be subject to physician review, which may result in denial.

#### **Opportunity for provider to appeal audit findings:**

- DRG Validation Audits: If the provider and the contracted audit agent continue to disagree

about the audit findings after a rebuttal has been filed and the original audit findings are upheld, the provider will be given another opportunity to submit a written appeal directly to Tufts Health Plan in order to have the audit determination evaluated by another inpatient coder. Provider appeals are to be sent directly to Tufts Health Plan with a copy of the complete medical record within 30 calendar days of the Final Audit Report Date. All audit determinations will stand and the findings deemed final if the provider fails to submit a written appeal to Tufts Health Plan or to communicate agreement with audit findings within 30 calendar days of the audit Final Audit Report Date.

- **DRG Readmission Audits:** If the provider and the contracted audit agent continue to disagree about the audit findings after the rebuttal opportunity, the provider will be given another opportunity to submit a written appeal directly to Tufts Health Plan. All appeals should be submitted within 30 calendar days of the Final Audit Report Date and include a copy of the complete medical record. If no provider appeal is submitted to Tufts Health Plan within 30 calendar days of the Final Audit Report Date, the audit findings will stand and the readmission claims will be subject to denial.

Tufts Health Plan will make a final determination regarding the appealed audit findings, via the Tufts Health Plan DRG appeals process, and communicate such determination in writing directly to the provider and Tufts Health Plan's contracted audit agent.

Tufts Health Plan will not accept retrospectively amended medical records or physician queries beyond 30 calendar days from the service date. Tufts Health Plan considers medical record documentation and/or physician queries present in the chart at the time the audit notification is made to the provider as the official record to support services provided for the basis of coverage or reimbursement determination.

Parties to an audit shall strive to eliminate ongoing problems or questions whenever possible as part of the audit process.

#### **Confidentiality and Authorizations for Audits**

- All parties to the audit must comply with federal and state laws, including but not limited to HIPAA, ARRA and all applicable contractual agreements regarding the confidentiality of patient information.
- Tufts Health Plan's contracts with the providers allow for access to medical record information for purposes of audit.
- As this activity falls within the scope of "health care operations," as that term is defined in the HIPAA Privacy Regulations, a separate, signed patient authorization will generally not be required by providers in order for Tufts Health Plan or the audit firm to conduct an audit. The provider will inform Tufts Health Plan on a timely basis if there are any federal or state laws prohibiting or restricting review of the health record that would be otherwise permitted under the Privacy Regulations.
- Provider will furnish the legal citation for any such law and will take remedial steps to facilitate the audit, including, but not limited to, redacting those portions of the medical record accorded privacy pursuant to the applicable state or federal law or securing the appropriate member consent.

#### **Scope of the DRG Validation Audit**

The audit scope will include verification of the:

1. Physician-ordered inpatient status
2. Accuracy of the diagnostic code assignment(s)
3. Accuracy of the procedural code assignment(s)
4. Accuracy of the sequencing of the principal diagnosis and procedure codes
5. Accuracy of present on admission indicator assignment(s)
6. Accuracy of DRG grouping assignment and associated payment

7. Accuracy of Discharge Disposition Status Code assignment
8. Other factors that may impact DRG assignment and/or claim payment
9. DRG readmission claim review under the readmission language in the [Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#)
10. Compliance with Tufts Health Plan's payment policies, including but not limited to, those policies that address DRG Inpatient Facility, Never Events, Hospital-Acquired Conditions, Readmissions, and/or Transfers to Another Acute-Care Hospital

Audit determination will be based on the documentation present in the medical record at the time of audit notification to the provider as the basis for the audit determination.

#### **DOCUMENT HISTORY**

- May 2019: Policy created

#### **AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan 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 the provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan's [audit policies](#), refer to our website.

This policy provides information on Tufts Health Plan 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 Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink<sup>SM</sup> for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.