Chapter 7 Addendum C

Hospital Adjustments

This review of hospital-requested claim adjustments assures that the correct diagnosis and procedure information is provided on the adjusted claim form. Thus, the correct Diagnostic Related Group (DRG) can be determined and the adjustment difference can be paid by the contractor.

A hospital may file an adjusted claim within the time period established by the contractor. A change in the principal diagnosis or the sequencing of the diagnoses or procedures may result in a change to a DRG with a higher weight providing for a higher reimbursement rate. Such cases should be closely reviewed before the hospital sends the cases to the contractor for adjusted payment.

When a hospital wishes to submit an adjusted claim, the hospital must send the case directly to the contractor to be reviewed within 60 days of the date of the initial remittance advice. The hospital must provide all of the following information within the 60-day time frame:

- A copy of the initial remittance advice;
- A copy of both the original and updated attestation OR
- A copy of the original attestation which has been corrected and corrections initialed and dated by the attending physician;
- The codes submitted for adjustment;
- An explanation of why the original codes were submitted incorrectly;
- A copy of the original claim form (CMS 1450 UB-04);
- A copy of the adjusted claim form;
- A copy of the medical record as required for performing admission review and DRG validation;
- If coding changes are based on newly acquired clinical information, a copy of such information (e.g., autopsy report).

The contractor shall check the date on the remittance advice to determine if the request for adjustment is made within 60 calendar days from the date of the remittance advice. If the 60 day period has expired, the contractor shall deny the claim adjustment and return it to the hospital with a letter explaining the reason for the denial.

Note: If all required documents are not provided, the case shall be returned to the hospital as incomplete. If the required documents are returned to the contractor within the 60-day time frame, the case shall be reviewed. If returned after the 60-day time frame, the case will not be reviewed.

If the hospital submits a request for a higher weight DRG on a case that has previously been scheduled for retrospective review, the case shall be returned to the hospital without review. DRG validation is performed during routine review procedures.

If the 60-day period has not expired and all of the required information has been submitted, the contractor shall use the adjusted codes to regroup the case to determine if it regroups to a higher weight DRG. Only adjusted claims that result in a higher weight DRG will be reviewed. If the case does not regroup to a higher weight DRG, the case shall be returned to the hospital without review. If the case does regroup to a higher weight DRG, all required reviews shall be performed. When potential denial or a coding change other than that requested occurs, appropriate notice letters shall be issued.

The adjusted claim shall be stamped as "APPROVED" or "DENIED" for DRG validation and returned to the hospital along with a letter stating the review results. The hospital then submits an "APPROVED" adjusted claim to the contractor and the "APPROVED" decision stamp flags the claim for adjusted payment. Adjusted claims cases resulting in higher weight DRGs are not eligible for re-review.

The Request for Higher Weight DRG Review form has been developed for use by hospitals in requesting review of higher weight DRG claim adjustments. This form must be completed and submitted with all requests. This form has been developed to assist hospitals in assuring that all required documents are sent with the request for review. Such requests may only be submitted by hospitals. Vendors or consultants may not request higher weight DRG reviews. Any record submitted by these individuals will be returned to the hospital. ALL REQUESTS FOR HIGHER WEIGHT DRG REVIEW MUST BE RECEIVED WITHIN 60 DAYS FROM THE DATE OF THE INITIAL REMITTANCE ADVICE.

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