

# UConn HEALTH

**POLICY NUMBER 2002-40**

**January 12, 2016**

## **POLICY: PAYMENT ERROR PROTECTION - MEDICARE REIMBURSEMENT**

Medicare payment audits completed in the late 1990's revealed the need for quality review for payment for Medicare patient inpatient hospitalizations. The Payment Error Prevention Program (PEPP) is focused on three critical components:

1. Efforts to improve and insure correct coding and Diagnostic Related Group (DRG) assignment of inpatient records.
2. Review to insure that the correct care is being provided in the correct setting based on documentation in the inpatient medical record
3. Review to insure that there is appropriate physician documentation to support acute level of care and DRG assignments

### **PROCEDURE:**

1. All inpatients will be evaluated by members of the Department of Case Management for appropriate admission to the inpatient setting. Criteria for evaluation will be accepted categories for severity of illness and intensity of service.
2. Patients who do not meet acute stay criteria will be presented to the house staff and attending physician for review and discussion of care needs.
3. In cases where it is determined that the patient does not meet acute care criteria, arrangements will be made for safe discharge.
4. The Case Manager working on the case will notify the department of Patient Financial Services about any Medicare patient admission where acute level of care was not warranted.
5. Medicare Part A will be billed as a "no payment bill" to notify them of a patient not meeting criteria for acute level of care. Medicare Part B will be billed for ancillary services as allowed in Medicare regulations.

### **Medical Records:**

1. All inpatient records are coded according to Medical Record's coding policies and procedures and in addition follow the American Hospital Association, and Medicare coding guidelines for the most accurate Diagnostic Related Group's assignment based upon the documentation provided in the medical record.

2. The coding staff will utilize a physician query form when the documentation in the medical record is unclear and needs further clarification from the attending physician. The physician's response/clarification must be documented in the patient's medical record. Query response forms are kept as part of the patient's legal medical record. Medical records will not release the account for billing until the physician documentation on the medical record supports the DRG assignment.
3. DRG assignments that are not reflective of the documentation in the medical record will be reviewed by the coding manager in conjunction with physician of the record.
4. On-going review of coding practices and DRG assignments will be performed by the coding manager on a monthly basis.
5. Any correspondences received by a third party payer regarding recommendations for a DRG change will be reviewed by the coding manager in conjunction with physician of the record. Any necessary changes will be made. If we are not in agreement with the third party payer's recommendations, then we have the right to appeal that recommendation. Appeals will be done by the coding manager with input from the medical staff.

Jeffrey Geoghegan (Signed)

1/14/16

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**Jeffrey Geoghegan**  
**Chief Financial Officer**

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**Date**

Andrew Agwunobi (Signed)

1/22/16

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**Andrew Agwunobi, M.D., M.B.A.**  
**Chief Executive Officer**  
**Executive Vice President for Health Affairs**

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**Date**

New Policy: 9/13/02

Revised: 1/12/16