



Cotiviti  
 <<<Address Line 1>>>  
 <<<Address Line 2>>>  
 <<<City, State Zip>>>

<<<Date>>>

**CCV - Audit Determination - Change**

<<<Provider Name>>>  
 <<<Provider Address 1>>>  
 <<<Provider Address 2>>>  
 <<<City, State Zip>>>

Dear <<<Provider Name>>>:

On behalf of Blue Cross Blue Shield of North Dakota (BCBSND), Cotiviti has completed a review of the following inpatient claim. Based upon the records reviewed, we have determined that a change is required as shown in the audit determination results below. Please follow the instructions below and return your response to Cotiviti within 45 calendar days of this letter date.

If you have any questions, please contact Cotiviti Provider Services at <<< (XXX) XXX-XXXX >>>, Monday – Friday from 7:00 AM to 4:00 PM CST/CDT. Thank you for your cooperation.

Sincerely,

Cotiviti

<b>Patient Account #:</b>	XXXXXXXXXXXXXXXXXXXX	<b>Subscriber ID:</b>	XXXXXXXXXXXXXXXXXXXX
<b>Facility:</b>	XXXXXXXXXXXXXXXXXXXX	<b>Dependent ID:</b>	XXXXXXXXXXXX
<b>Tax ID:</b>	99-99999999	<b>Patient Name:</b>	<<< Last Name, First Name >>>
<b>Provider ID:</b>	999999	<b>Patient DOB:</b>	99/99/9999
<b>Payer Name:</b>	<<< Payer >>>	<b>Patient Gender:</b>	X
<b>Payer Claim #:</b>	XXXXXXXXXXXXXXXXXXXX	<b>Date of Admission:</b>	99/99/9999
<b>Cotiviti ID #:</b>	999999999999	<b>Date of Discharge:</b>	99/99/9999
<b>Claim Paid Amount \$:</b>	99999999.99	<b>Adjusted Claim Paid Amount \$:</b>	99999999.99

**Date Audit Performed:** 99/99/9999

**Audit Determination:** <<<Disagree with DRG as submitted – see explanation>>>

**Explanation:** <<<Insert audit determination criteria here>>>

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Cotiviti is an independent company offering payment integrity services on behalf of Blue Cross Blue Shield of North Dakota.

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Cotiviti, <<<Address Line 1>>> <<< Address Line 2>>> <<< City State Zip>>> T:<<<PHONE>>> F:<<<FAX>>>



ND

COTIVITI

<<<Date>>>

CCV- Audit Determination - Change

**Patient Account #:** XXXXXXXXXXXXXXXXXXXX  
**Facility:** XXXXXXXXXXXXXXXXXXXX  
**Tax ID:** 99-99999999  
**Provider ID:** 999999  
**Payer Name:** <<< Payer >>>  
**Payer Claim #:** XXXXXXXXXXXXXXXXXXXX  
**Cotiviti ID #:** 999999999999

**Subscriber ID:** XXXXXXXXXXXXXXXX  
**Dependent ID:** XXXXXXXXXXXX  
**Patient Name:** <<< Last Name, First Name >>>  
**Patient DOB:** 99/99/9999  
**Patient Gender:** X  
**Date of Admission:** 99/99/9999  
**Date of Discharge:** 99/99/9999

Submitted on Claim			Post Audit Result		
<b>Allowed DRG:</b>	170		<b>Allowed DRG:</b>	170	
<b>Discharge Disposition:</b>	03		<b>Discharge Disposition:</b>	03	
<b>Severity:</b>	XX		<b>Severity:</b>	XX	
<b>Birth Weight:</b>	999999		<b>Birth Weight:</b>	999999	
<b>Diagnostic Codes:</b>	<b>ICD Indicator:</b>	<b>POA:</b>	<b>Diagnostic Codes:</b>	<b>ICD Indicator:</b>	<b>POA:</b>
Primary Diag	10	Y	Primary Diag	10	Y
Diag 2	10	Y	Diag 2	10	Y
.			.		
.			.		
.			.		
Diag 25	10	Y	Diag 25	10	Y
<b>Procedure Codes:</b>	<b>ICD Indicator:</b>		<b>Procedure Codes:</b>	<b>ICD Indicator:</b>	
Primary Procedure	10		Primary Procedure	10	
Proc 2	10		Proc 2	10	
.			.		
.			.		
.			.		
Proc 25	10		Proc 25	10	

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ND

COTIVITI

<<<Date>>>

CCV - Audit Determination - Change

<b>Patient Account #:</b>	XXXXXXXXXXXXXXXXXXXX	<b>Subscriber ID:</b>	XXXXXXXXXXXXXXXXXXXX
<b>Facility:</b>	XXXXXXXXXXXXXXXXXXXX	<b>Dependent ID:</b>	XXXXXXXXXXXX
<b>Tax ID:</b>	99-99999999	<b>Patient Name:</b>	<<< Last Name, First Name>>>
<b>Provider ID:</b>	999999	<b>Patient DOB:</b>	99/99/9999
<b>Payer Name:</b>	<<< Payer >>>	<b>Patient Gender:</b>	X
<b>Payer Claim #:</b>	XXXXXXXXXXXXXXXXXXXX	<b>Date of Admission:</b>	99/99/9999
<b>Cotiviti ID #:</b>	999999999999	<b>Date of Discharge:</b>	99/99/9999

**Agreement with Determination**

If you agree with this decision, please sign and submit a claim adjustment form with a copy of this letter and Audit Determination report attached within 45 calendar days of this letter date to: <<< Cotiviti >>>, <<< Address Line 1 >>>, <<< Address Line 2 >>>, City, State Zip >>>. If no adjustment request is received within this timeframe, the claim will be denied.

Claim adjustment forms specific to DRG Validation Coding Audits can be found at:

<https://www.bcbsnd.com/providers/news-resources/forms-documents>

<b>Printed Name</b>	<b>Signature of Representative</b>	<b>Title</b>	<b>Date</b>

**Disagreement with Determination**

If you disagree with this decision, you have a right to request a reconsideration of the audit determination. Please mail your written reconsideration request, and additional supporting documentation, within 45 calendar days of this letter date to the Cotiviti first reconsideration address below. **Note: Reconsideration instructions enclosed.**

In fairness to all providers, a claim adjustment (change to claim agreement) or request for reconsideration received by Cotiviti after the 45-day time limit has ended will result in a claim denial. Any further opportunity for payment of the claim is waived by the provider for failure to respond timely.

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## IMPORTANT INFORMATION ABOUT YOUR RECONSIDERATION RIGHTS

Cotiviti conducts audits on behalf of Blue Cross Blue Shield of North Dakota (BCBSND) in accordance with current industry standards and practices. The mission of the Cotiviti clinical and coding auditor team is to provide complete and accurate results with fair perspective.

### **First Reconsideration**

If you disagree with the audit findings and have additional information to supply, you have the right to request reconsideration. To exercise this right, file your written request, along with additional documentation to support reimbursement of the claim as originally billed, within 45 calendar days of this letter date. All requests for review must be in writing and sent to:

**Cotiviti**  
**<<<Address Line 1>>>**  
**<<<Address Line 2>>>**  
**<<<City, State Zip>>>**

Upon receipt of your reconsideration, Cotiviti will review the original audit determination and any additional information submitted in support of your reconsideration. Cotiviti will send you a reconsideration response within 45 days indicating that the original audit determination has been upheld or overturned, or a new audit determination may be issued. If you disagree with the reconsideration response you have the right to submit a second reconsideration within 45 calendar days of this letter date.

### **Second Reconsideration**

If you receive an unfavorable decision on the first reconsideration, you may file a request for second reconsideration. To exercise this right, file your written request, along with any new supporting documentation to support reimbursement of the claim as originally billed, within 45 calendar days of this letter date. All requests for second review must be in writing and sent to:

**Manager of SIU/Provider Audit**  
**Blue Cross Blue Shield of North Dakota**  
**4510 13<sup>th</sup> Avenue S**  
**Fargo, ND 58121**

BCBSND will issue a decision within 45 calendar days of this letter date. In order to ensure that the second review receives a fair and impartial review, the second review will be made by clinicians and/or specialists who did not conduct the original audit of the claim.

This is the final determination; no further review or reconsideration will be accepted by Cotiviti or BCBSND.

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