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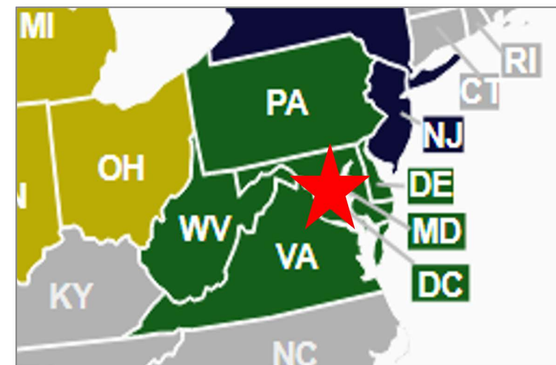
Claim Review Services

First Year Review Findings

Higher Weighted Diagnosis Related Group (HWDRG) Reviews

About Livanta LLC

- **Established in 2004, known for health care innovation, applications, and solutions**
- **Privately-held, government contracting firm**
- **Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO)**
  - 11th Statement of Work, 2014-2019
    - Case Review Services for Areas 1 and 5
  - 12th Statement of Work, 2019-2024
    - Case Review Services for Regions 2, 3, 5, 7, and 9
    - National Medicare Contractor for Claim Review Services



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Presentation Purpose

- Outline the goals of Livanta's Claim Review Services program for CMS
- Review the claim review process for HWDRG
- Present findings from the first year of HWDRG claim reviews

HWDRG Claim Reviews

- **Claim reviews for higher-weighted DRG adjustments focus on medical necessity of the inpatient admission and DRG validation.**
- **This review activity helps ensure that the patient's diagnostic, procedural, and discharge information is coded and reported properly on the hospital's claim and matches documentation in the medical record.**
- **Four Goals of Claim Review Services:**
  1. Work toward decreasing Medicare's paid claims error rate
  2. Address medical review related coverage, coding, and billing errors
  3. Protect the Medicare Trust Fund
  4. Provide education to providers and other stakeholders related to claim review findings

Claim Review is a Unique Program

- **The BFCC-QIO Claim Review Services program is not incentivized to find errors.**
- **Providers may provide supplemental documentation for initially denied claims.**
- **Hospitals may request education sessions at any point in the audit process.**
  - Can be specific to discuss individual cases prior to final denial decisions
  - Can be general to obtain information on appropriate ICD-10-CM and ICD-10-PCS coding and associated guidelines

Improper Payment Reduction Strategy (IPRS)

- **To assist in reducing the Agency's paid claims error rate, Livanta developed an Improper Payment Reduction Strategy (IPRS). The IPRS outlines the sampling strategy for HWDRG claims and was approved by CMS.**
- **Each month, Livanta downloads eligible paid claims for HWDRG from the CMS database.**
- **Each claim is scored to account for the influences of volume, cost, and clinical risk of improper payment.**
  - For volume, the DRGs associated with downloaded claims are aggregated.
  - For cost, paid amounts are summed by associated DRGs.
  - For clinical risk, all DRGs have been ranked using environmental scans as a starting point.
  - Not all providers will be sampled.

IPRS Components

Volume

- The DRGs associated with downloaded claims are aggregated and sorted from highest to lowest volume.
- The volume range is broken into three groups and the component DRGs are scored from most (3) to least (1) volume impact.

Cost

- Paid amounts are summed by DRG and sorted from highest to lowest dollar amounts.
- The dollar range is broken into three groups and the component DRGs are scored from most (3) to least (1) dollar impact.

Clinical Risk

- All DRGs have been ranked using environmental scans as a starting point.
- Each DRG is scored from most (3) to least (1) clinical risk impact.

IPRS Final Claim Score

- **IPRS component scores are applied to the claim by DRG and added.**

- **The sum of the components is the Final IPRS Claim Score.**

HWDRG Review Process

1. **Livanta selects a monthly sample and requests medical records from hospitals.**
2. **The claim review team reviews the medical record for support of the adjusted DRG.**
   - Coding auditors screen and approve as appropriate or issue technical coding changes that affect the DRG.
   - Claims that need a clinical review for added diagnoses or medical necessity of admission are referred to physician reviewers for final review.
3. **If a claim is not approved, Livanta notifies the hospital.**
4. **Hospitals have 20 days to respond to the denial and send additional documentation if necessary.**
5. **Livanta re-reviews the claim if the hospital responds to initial findings.**
6. **The final review results are sent to the hospital and the appropriate Medicare Administrative Contractor (MAC) for re-billing.**
7. **Hospitals may appeal a DRG change decision through Livanta.**

Table 1: Year 1 HWDRG Overall Findings

Description	Number	Percent
Approved	47,615	88%
DRG Changes	6,550	12%
Admission Denials	86	<1%
Total Claims Reviewed	54,251	100%

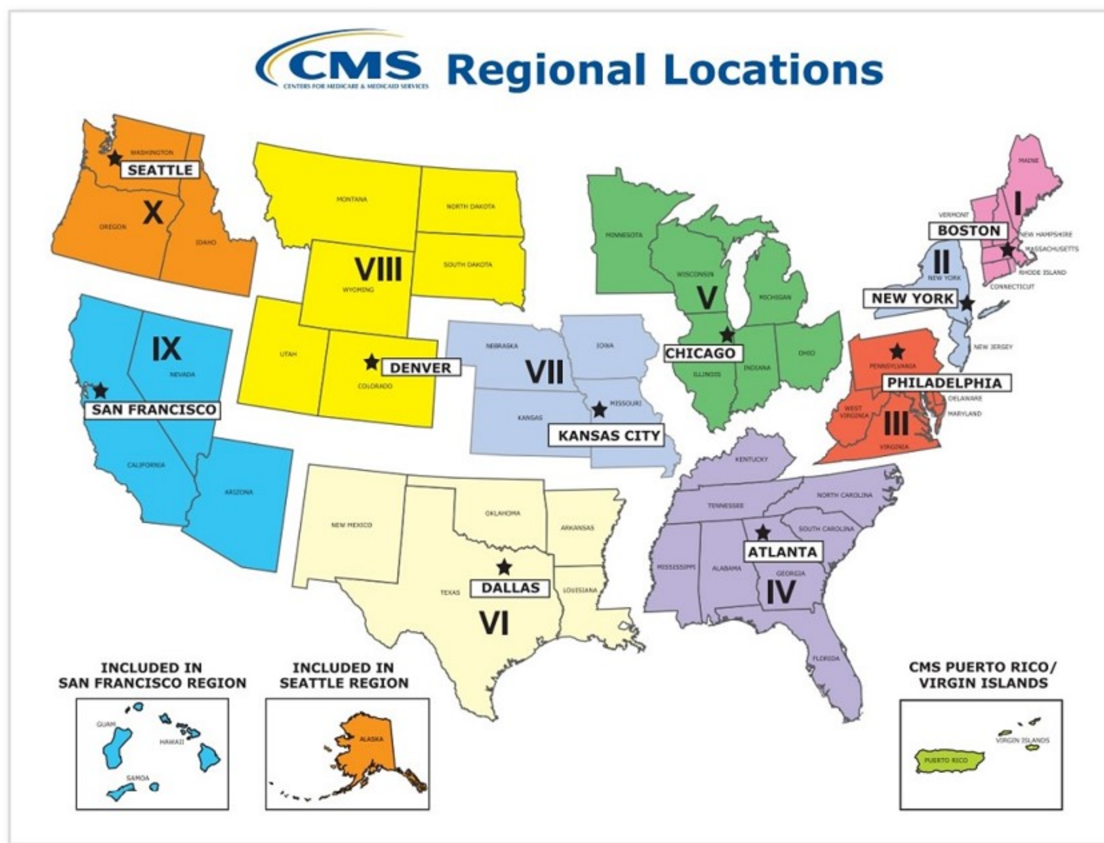
Table 2: HWDRG Code Level Changes

DRG changes occur at the individual code level.

- Technical coding errors involve inappropriate application of the ICD-10-CM/PCS coding guidelines.
- Clinical coding errors are reviewed by Livanta physician reviewers and involve a lack of evidence to support the diagnosis represented by the code.

Disagreement Reason	Count of Codes	Percent in Error
Clinical	4,804	43%
Technical	6,480	57%

Map of CMS Regions



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View online map at:
https://www.cms.gov/smg-overview/security-guidelines-office-location

Table 3: HWDRG Findings by Region

CMS Region	DRGs Changed	Claims Reviewed	Regional DRG Error Rate	Region's Contribution to Total DRG Changes
1	149	1,526	10%	2%
2	193	1,829	11%	3%
3	370	3,695	10%	6%
4	2,794	19,589	14%	43%
5	279	4,199	7%	4%
6	1,420	10,726	13%	22%
7	328	2,930	11%	5%
8	193	1,621	12%	3%
9	722	6,736	11%	11%
10	102	1,400	7%	2%
TOTAL	**6,550**	**54,251**	**12%**	**100%**

Regional Observations

- Region 4 accounted for the most claims reviewed and the highest number of DRG changes.
- Region 4 and Region 6 combined accounted for 64 percent of all DRG changes for the claims reviewed.

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Table 4: Reasons for DRG Change

Error Classification	Count of Codes	Percent in Error
No Documentation of Diagnosis	3,525	31%
Changed Principal Diagnosis	3,414	30%
Principal Diagnosis Re-sequenced	1,922	17%
Incorrect Diagnosis Code	1,062	9%
Specificity of Diagnosis Code	444	4%
Missed Diagnosis Code	336	3%
No Documentation of Procedure	248	2%
Incorrect Procedure Code	193	2%
Specificity of Procedure Code	75	1%
Missed Procedure Code	65	1%

- **Over 60 percent of DRG errors occurred as a result of changing the principal diagnosis and/or finding no documentation supporting an added diagnosis.**
- **In 17 percent of cases the principal diagnosis submitted did not meet the accepted definition.**

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HWRG Top Reasons for Denial

- **Selection of a principal diagnosis that is not supported by the medical record and coding guidelines**
- **Submission of a major complication or comorbidity (MCC) or CC that is not supported by the documentation in the medical record**
  - Common diagnoses in this category are sepsis, encephalopathy, and malnutrition
- **Inappropriate query submissions and unsupported responses**

Table 5: Reversed HWDRG DRGs

4,346 of the 6,550 DRG changes (66 percent) reverted to the DRG prior to the adjustment to HWDRG.

HWDRG	Description	Claims Changed to Prior DRG
871	Septicemia or Severe Sepsis w/o MV >96 hrs with MCC	892
682	Renal Failure with MCC	237
872	Septicemia or Severe Sepsis w/o MV >96 hrs without MCC	141
811	Red Blood Cell Disorders with MCC	137
853	Infectious and Parasitic Diseases with OR Procedure with MCC	111
640	Miscellaneous Disorders of Nutrition Metabolism Fluids and Electrolytes	107
689	Kidney and Urinary Tract Infections with MCC	106
064	Intracranial Hemorrhage or Cerebral Infarction with MCC	76
291	Heart Failure and Shock with MCC	70
193	Simple Pneumonia and Pleurisy with MCC	68

Table 6: Top DRGs Changed

- **Sepsis DRGs (871 and 872) comprise the largest percentage of DRGs found to be in error.**
- **The renal failure DRG (682) accounted for the second largest percentage of DRG errors.**

HWDRG	DRGs Changed	DRGs Reviewed	DRGs Contribution to Total DRG Changes
871	1,238	4,967	19%
682	354	1,920	5%
811	199	748	3%
872	173	672	3%
945	154	268	2%
853	149	1074	2%
640	143	867	2%
689	128	652	2%
291	117	1577	2%
064	99	893	2%

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HWDRG Education

- When a monthly sample contains 30 or more claims for one provider, these results are bundled into a provider sample for consolidated feedback when all the reviews are final.

- Livanta will reach out to provide education when the sample shows an error rate of 20 percent or more.

- Hospitals can contact Livanta at any time for education related to ICD-10-CM/PCS coding questions for their Part A claims.

Additional Claim Review Educational Resources

The *Livanta Claim Review Advisor* and Provider Bulletins

Livanta publishes a monthly e-journal of claim review findings and other helpful information. The *Livanta Claim Review Advisor* provides monthly updates, best practices and critical program information for short stay review and HWDRG reviews. Livanta also publishes claim review provider bulletins as needed to ensure providers receive time-sensitive notices.

Subscribe now

www.LivantaQIO.com/en/ClaimReview/Provider/bulletin.html

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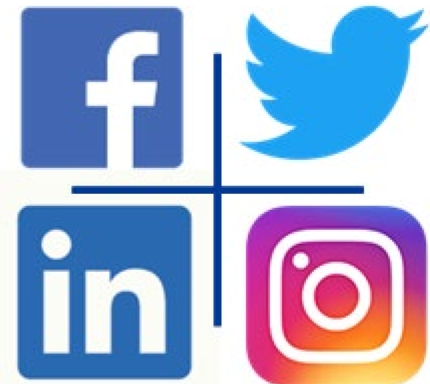

Contact Information

*For general questions about this presentation or to request additional education contact:

ClaimReview@Livanta.com

*Please do not email Protected Health Information (PHI) or Personally Identifiable Information (PII)

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This material was prepared by Livanta LLC, the Medicare Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) for Medicare Regions 2, 3, 5, 7, and 9 under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 12-SOW-MD-2019-QIOBFCC-PROV17