April 2025

THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

Volume 1, Issue 38 www.LivantaQIO.com Open in browser.

Higher-Weighted DRG Review – Decreasing Medicare's Paid Claims Error Rate

The contract for Medicare claim review services instructs the BFCC-QIO to work toward decreasing Medicare's paid claims error rate and addressing medical review-related coverage, coding, and billing errors in support of the strategic goal of Beneficiary Oversight, which encompasses protecting the Medicare Trust Fund.

The Improper Payment Reduction Strategy (IPRS) developed by Livanta is used as a tool to accomplish these objectives. The IPRS outlines Livanta's strategy of sampling claims for higher-weighted diagnosis related group (HWDRG) reviews. Livanta updates the IPRS annually and incorporates empirical findings from the HWDRG reviews finalized during the previous year.

BFCC-QIO Authority to Conduct Claim Review

HWDRGs are adjusted claims for which the hospital was paid a higher payment than was previously submitted. A hospital reimbursed under the Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) may request HWDRG payment when the hospital determines that the clinical circumstances of the case warrant a claim correction that results in payment of a higher-weighted Medicare Severity DRG (MS-DRG), which increases the reimbursement to the hospital. Post-payment review of these HWDRG adjustments is mandated under statute and CMS instruction as quoted in the CMS QIO Manual: *Perform DRG validation on PPS cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)). 42 CFR 476.71.*

Livanta devised a flexible approach to sampling that could accommodate monthly fluctuations in HWDRG claim volumes for potential selection and review, as outlined in the IPRS. The goal of this approach is to sample and review HWDRG claims in a manner that is more likely to uncover errors than would a purely random sample, while still being able to reconstruct justifiable regional and national improper payment amounts for all paid HWDRG claims. The second goal of claims review is to identify high-risk hospitals, educate them, and, if they are persistently non-compliant, refer them for further review.

HWDRG Sampling Strategy and Claims Weighting

Livanta's recently updated IPRS was informed by completed HWDRG reviews. The prior years of completed HWDRG reviews provide data supporting evidence-based sampling. This approach uses historical data to identify diagnosis-related groups (DRGs) most likely to be paid in error. The details of the methodology are described below.

Livanta extracts all eligible HWDRG adjustments from the CMS claims database each month. Each claim is prioritized for sampling according to its CMS Region, representative frequency, and clinical likelihood of an improper payment. This prioritization process generates an improper payment risk score used to guide sample selection.

Samples are assessed at the stratum (risk score) level to ensure statistical independence and representativeness in both information content and typical values. This sample validation process, using statistically valid quality assurance tests, firmly establishes the reliability and validity of the results found from the samples.[1]

[1] Allen, M. & Yen, W. (1979). Introduction to Measurement Theory 1st Edition, p. 75. ISBN-13: 978-0818502835.

Sampling Prioritization Scores

In keeping with its IPRS, Livanta applies a three-part prioritization scoring methodology to HWDRG claims, given that a sufficient number of eligible claims are available for any given month to conduct sampling. The three components that are individually scored are volume, clinical risk of improper payment, and cost for each HWDRG adjusted claim. The individual scores are added together to assign a risk weight for each HWDRG claim eligible for sampling. Claims with higher computed risk scores are sampled at a higher rate than lower risk-score claims. The individual risk score components are analyzed and adjusted as needed based on ongoing review outcomes.

Table 1: HWDRG Compensatory Score

Component	Score = 1	Score = 2	Score = 3
Volume by DRG	Low Volume DRGs	Medium Volume DRGs	High Volume DRGs
Clinical Risk	Low Risk by DRG	Medium Risk by DRG	High Risk by DRG
CMS Region	Low Risk by Region	Medium Risk by Region	High Risk by Region

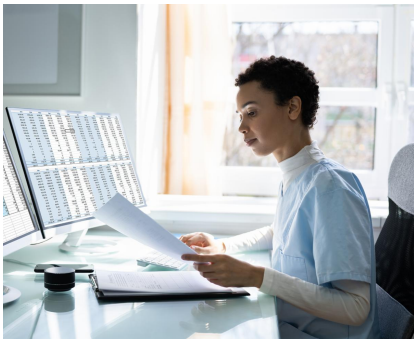
Sampling Components

- Volume by DRG: HWDRGs on the adjusted claim are sorted by volume and scored accordingly
- Clinical risk: analysis of the DRGs most often denied inform this category for ranking the DRGs as high, medium, or low risk of improper payment
- CMS Region: analysis of the HWDRG errors by region inform this category for ranking the claims as high, medium, or low risk of improper payment

Sample and Extrapolation Adjustments

Unless the total listing of eligible claims (the population) is sufficiently large, there will be times when the allocated number of claims for each stratum will not be met by the number of claims that are eligible for sampling from the designated strata. Under those conditions, the additional claims are selected from the higher priority strata, in concert with the stated goals of the IPRS.

Individualized Hospital Results



When a hospital has had at least 30 claims sampled and reviewed in a monthly sample, those claims are aggregated to form a hospital-specific report, which is then sent to the hospital. The report summarizes information the hospital has already received during the course of the monthly claims review process and includes identified areas for educational intervention where findings warrant.

Livanta aggregates individual provider results and assesses educational opportunities at the provider level. Provider samples are analyzed, and one-on-one education is scheduled with a Medical Director and Coding Educator if a high error rate is noted.

About Livanta

Livanta is the national Medicare Claim Review Services contractor under the Beneficiary

and Family Centered Care – Quality Improvement Organization (BFCC-QIO) Program. As the Claim Review Services contractor, Livanta validates the DRG on hospital claims adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the patient's diagnoses, procedures, and discharge status reported on the hospital's claim are supported by the documentation in the patient's medical record. Livanta's highly trained, credentialed coding auditors adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When needed, actively practicing physicians review for medical necessity and clinical validity based on the presence of supporting documentation and clinical indicators.

Post-payment review of these HWDRG adjustments is mandated under statute and in the Centers for Medicare & Medicaid Services (CMS) QIO Manual: Perform DRG validation on prospective payment system (PPS) cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)).

Read more: CMS, Quality Improvement Organization Manual, Chapter 4 - Case Review
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf

Questions?

Should you have questions, please email **ClaimReview@Livanta.com**, or visit the claim review website for more information:
https://www.livantaqio.cms.gov/en/ClaimReview/index.html