

THE LIVANTA CLAIMS REVIEW ADVISOR



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

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Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Appealing Livanta's Determinations

This month's issue of *The Livanta Claims Review Advisor* provides guidance to hospitals on how best to respond to potential or final determination letters from Livanta. Appeals are often denied because hospitals do not address the issues raised in the Livanta determination letters or the hospital responses are not timely. This month's issue of the *Advisor* explains the different types of HWDRG review determinations and offers suggestions for effective hospital responses for coding and medical necessity decisions that will support approvals.

Types of HWDRG Determinations

Hospitals may receive three types of HWDRG preliminary determinations from Livanta:

- Proposed MS-DRG Change – Preliminary Notice;
- Proposed Admission Denial – Preliminary Notice; and
- Proposed Admission Denial and Proposed MS-DRG Change – Preliminary Notice.

It is important to read the content of the preliminary notice to determine how best to respond. Note that the response to the preliminary notice is due within 20 days of the date of the letter, as noted in Section 4530 of the QIO Manual.

When responding to the combination notice for both admission denial and DRG change, a response that addresses only the DRG change will have no practical relevance since the determination of an admission denial will cancel the Part A claim and, thus, override the DRG change.

Appealing Technical Coding Issues

It is important to know the difference between DRG changes based on coding guidelines and those based on one or more diagnoses determined to be clinically invalid. The two types of DRG changes require very different approaches when appealing Livanta's decisions. If a DRG change is technical, meaning it was decided by a coding auditor, the appeal should only include references that are accepted as standard references for the coding industry. Acceptable references include medical record entries, Coding Clinic articles, the Official Coding Guidelines, the AHA coding handbook, AHIMA directives, the Federal Register, and medical dictionaries. When referencing guidelines, be sure to state the location of the specific guideline rather than preceding it with a generic statement such as "per the coding guidelines."

Livanta commonly sees responses from hospitals that do not address the issue(s) raised in the determination letter. The following list includes some examples of hospital responses that do not address the issue(s) raised in the determination letter:

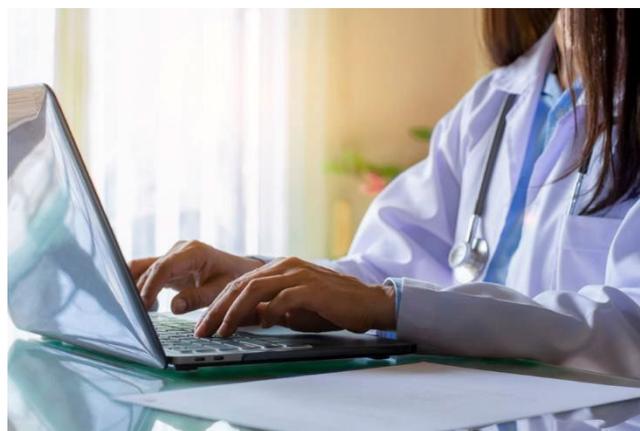
- The hospital submits a clinical argument for a technical coding issue.
- The hospital tries to support its reporting of a condition that was never documented in the medical record but for which some clinical indicators are present.
- The determination letter from Livanta was not closely read, and the hospital only resubmits the medical record without further comment.
- The hospital submits an appeal of a Livanta DRG decision that resulted in higher reimbursement, citing that it does not agree with the lower payment.
- The hospital states that it disagrees with Livanta's decision without explaining why it disagrees or providing any related guidelines or other support.
- The hospital does not provide a case-specific response related to Livanta's rationale for the DRG change.

Appealing Clinical Coding Issues

Clinical DRG changes are those that were decided by one of Livanta's physician reviewers and were based on clinical validation of specific diagnoses. In the determination letter, Livanta indicates that this is a clinical decision made by a physician in the DRG Change Rationale. If a DRG change is clinical, there is a note added at the beginning or the end of the rationale that clearly states that the decision was made by a physician reviewer as part of a clinical review.

The following list includes some examples of hospital responses that do not address the issue(s) raised in the determination letter.

- The hospital focuses on coding rules when the DRG change is based on a clinical rationale as described in the determination letter.
- The hospital does not address the rationale provided by Livanta's physician reviewer.
- A frequent argument against a DRG change is a Coding Clinic article from 4th Quarter 2016 titled "Clinical Criteria and Code Assignment." Hospitals often quote the first paragraph of the answer (the one that disallows coders from using clinical criteria when coding a record). The second paragraph of the same article addresses clinical validation as a separate function performed by a clinician (such as Livanta's physician reviewers).



Livanta is contracted with the Centers for Medicare & Medicaid Services (CMS) to validate HWDRG claims for both DRG and clinical accuracy. Credentialed and experienced coding auditors and board-certified, currently practicing physician reviewers are utilized for these validations.

Appealing Medical Necessity Decisions

A hospital response to a proposed admission denial should address the reasons cited in the proposed admission denial rationale of the preliminary notice sent by Livanta to the hospital. Support for Part A (inpatient) payment needs to address the conditions of the Two-Midnight Rule, which is the Medicare policy governing Part A payment effective in Fiscal Year 2013. Hospital responses citing commercial clinical decision support systems (e.g., InterQual, MCG) are ineffective since they do not address the Two-Midnight Rule.

As noted above, a hospital response to a combination letter of proposed DRG change and admission denial must address the admission denial portion. If this is not addressed, the preliminary results become final, and inpatient admission is denied. Appeals for admission denial related to the Two-Midnight Rule are handled by the appropriate Medicare Administrative Contractor (MAC).

Timing of Hospital Responses

The hospital response to a preliminary determination letter from Livanta is due within 20 calendar days from the date of the notice (§4530 QIO Manual). If the response is not received timely, the preliminary determination becomes final, as is written in the preliminary notice:

"We must receive your response within 20 days from the date of this letter to have it considered in our final determination. If no response is received within this timeframe the initial determination will become final."

For DRG changes, a response received from the hospital after the final determination letter has been issued is considered a request for re-review. Re-reviews are performed by a reviewer other than the one who made the initial determination. A re-review of a DRG change needs to be requested by the hospital within 60 days of the date on the final notification of a DRG change. As specified in 42 CFR 478.15(c), no additional review or appeal is available to the hospital.

"We are sending this letter to the attending physician and the hospital's QIO liaison. If you disagree with our determination, you may request a re-review from a different QIO reviewer within 60 days from the date of this notice."

For potential admission denials, a response received from the hospital after the final determination letter has been issued must be appealed to the appropriate MAC. This is noted in the final admission denial letter Livanta sends to the hospital.

OPPORTUNITY TO APPEAL

We are also notifying the Medicare Administrative Contractor (MAC) of our final determination. This letter with the claim information will be sent to the MAC and payment adjustments will be made. **The MAC will issue a Remittance Advice when your claim is adjusted, and a Demand Letter containing both the information regarding repayment of funds and your formal appeal rights.** The "Total Overpayment Amount to be Demanded" shall be reflected in the demand letter.

Good Documentation Practices



The best advice for consistently good documentation is to ensure that the reason for admission and final diagnoses are documented often and clearly. If the medical record lacks this documentation, the attending physician should explain why an undocumented condition is what occasioned the admission. This could occur in cases where the clinical workup took longer than expected. Other helpful hints for good documentation are as follows:

- Be sure that the major diagnoses are supported by clinical evidence from diagnostic studies, patient symptoms, examinations, and treatment provided.
- Given that the definition of principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission, it is important to document frequent updates, from admission to discharge, to illustrate any change between admitting diagnoses and the final discharge diagnoses.

In Conclusion

A substantial portion of hospital responses to Livanta's notices do not address the rationale provided in the determination letter. Some hospitals have responded only by sending another copy of the medical record without any further comment. When these are received by Livanta, they are processed as a hospital response that did not provide any additional information to change the determination. It is important to read Livanta's correspondence to confirm the content and distinguish between a request for the medical record and an outcome determination after review.

When responding to Livanta's determination, it is not necessary to resubmit the entire medical record. If a portion of the record supports the hospital's argument, it is only necessary to submit that portion with the appeal. Do not copy and paste portions of reports with no patient identifiers, as this cannot be used to ascertain the validity of the report for the claim in question.

To submit a valid appeal, the hospital should state disagreement with Livanta's findings and provide reasons for the disagreement, such as supporting documentation from the medical record, coding guidelines, Coding Clinic articles, or support for the Two-Midnight Rule in the case of a potential admission denial.

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 that have been adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the diagnoses, procedures, and discharge status of the patient 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 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.

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