

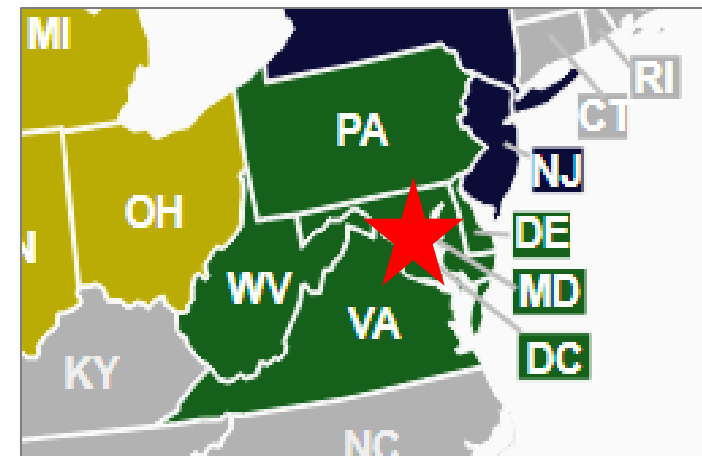
Claim Review Services

First Year Review Findings for Short Stay Reviews (SSR)



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



Presentation Purpose

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

Short Stay Claim Reviews

- **Claim reviews for short hospital stays focus on appropriate application of the Two-Midnight Rule.**
- **Inpatient admissions are generally payable under Medicare Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.**
- **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 Services

- **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 application of the Two-Midnight Rule

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 SSR claims and was approved by CMS.**
- **Each month, Livanta downloads eligible paid claims for SSR 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 were 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

- **SSR has one additional component for claim length of stay (LOS).**
- **LOS score is calculated for SSR claims:**
 - 0-day LOS is scored higher (i.e., 2)
 - 1-day LOS is scored lower (i.e., 1)
- **IPRS component scores are applied to the claim by DRG and added.**
- **The sum of the components is the Final IPRS Claim Score.**

Short Stay Review Process

- **Select monthly sample (only 0- and 1-day admissions are eligible)**
- **Request medical records associated with the sampled claims**
- **Review medical record using guideline on the next slide**
 - Trained review coordinators screen and approve as appropriate
 - Physician reviewers make determinations on claims that do not pass the first screen
- **Send initial review results if not initially approved**
- **Wait for hospital response (due in 20 days)**
- **Re-review if hospital responds, otherwise initial results become final**
- **Send final review results (denial or approval)**
- **Appeal of denial is handled by the Medicare Administrative Contractor (MAC)**

BFCC-QIO 2 Midnight Claim Review Guideline

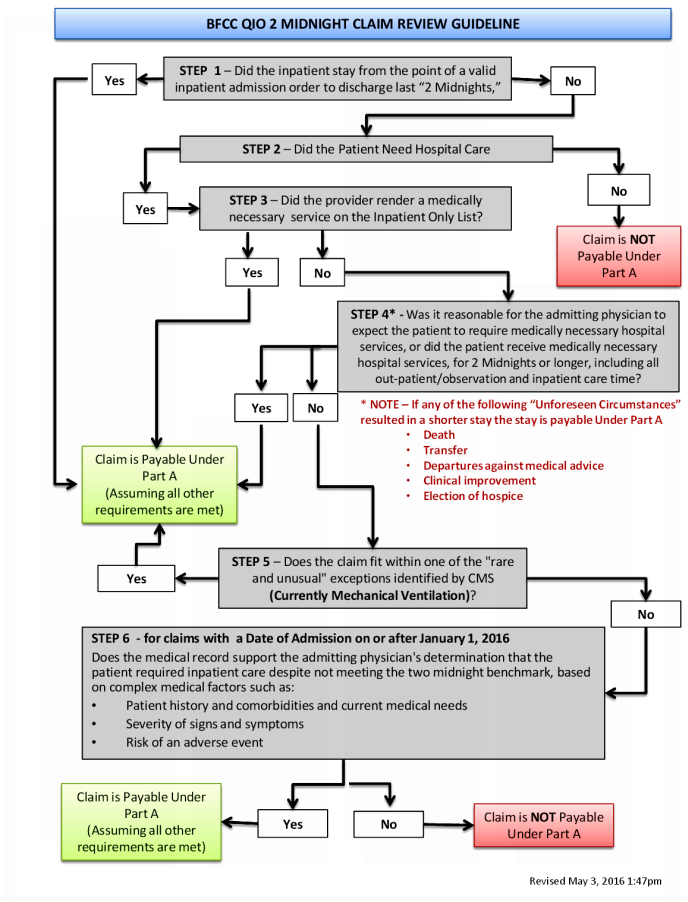


Table 1 and Table 2: Year 1 Reviews and Error Rates

Table 1: SSR Year 1 Reviews

86 percent of short stay reviews are approved.

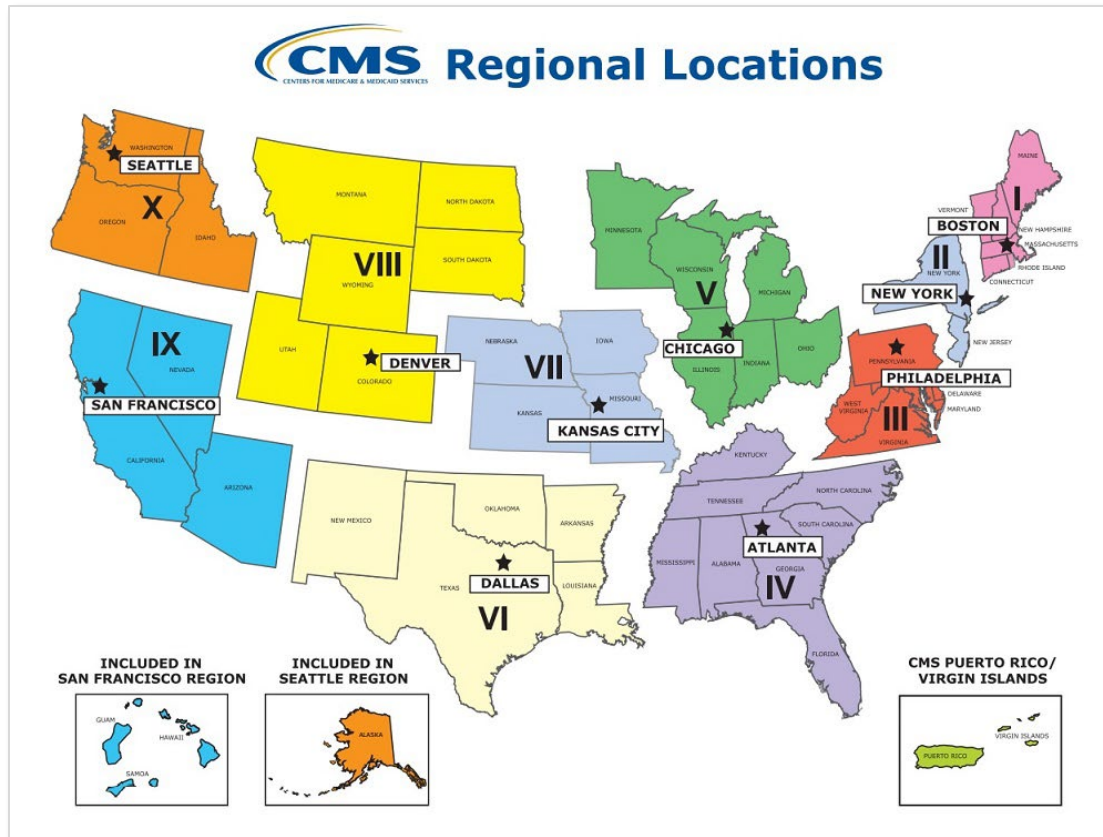
Description	Number of reviews	Percent of total
Approved	16,009	86%
Denied	2,663	14%
TOTAL	18,672	100%

Table 2: SSR Year 1 Error Rates

Claims with a 0-day length of stay (LOS) are more likely to be denied.

Length of stay	Number of claims reviewed	Error rate
0-Day	5,195	18%
1-Day	13,477	13%
TOTAL	18,672	14%

Map of CMS Regions



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

Table 3: SSR Findings by Region

Region	Claims Denied	Claims Reviewed	Denial Rate	Contribution to Total Denials
1	191	1,131	17%	7%
2	321	1,501	21%	12%
3	267	2,038	13%	10%
4	600	4,415	14%	23%
5	417	3,133	13%	16%
6	311	2,033	15%	12%
7	123	952	13%	5%
8	80	582	14%	3%
9	298	2,285	13%	11%
10	55	602	9%	2%
TOTAL	2,663	18,672	14%	100%

Regional Observations

- Highest number of claims reviewed: **Region 4**
- Highest number of denials: **Region 4**
- Highest regional denial rate: **Region 2**
- Nearly a quarter of the total denials: **Region 4**



A Word about Denials

Common reasons for a short stay claim denial:

- Insufficient documentation to support a two-midnight expectation at the time of the inpatient admission order. (Review Guideline Step 4)
- The plan of care does not support a reasonable expectation of two midnights of hospital care. (Review Guideline Step 4)
- The need for inpatient care without a two-midnight expectation is not supported based on the patient's documented medical needs and risk for adverse event (Review Guideline Step 6)

Technical Denials (TDs):

- TDs are not factored into the review findings.
- A TD is issued when the requested medical record for the sampled claim is not submitted to Livanta for review.
- TDs may be reversed upon receipt of the requested medical records.

Table 4: SSR Denials by Service Category

MDC	MDC Description	Claims Denied	MDC Contribution to Total Denials
05	Circulatory System	954	36%
06	Digestive System	430	16%
08	Musculoskeletal System and Connective Tissue	236	9%
01	Nervous System	234	9%
11	Kidney and Urinary Tract	175	7%
04	Respiratory System	134	5%
10	Endocrine, Nutritional, and Metabolic System	128	5%
-	TOTAL	2,291	86%

Denials by Service Category

- **Seven major diagnostic categories (MDC) comprise 86 percent of all denials.**
- **More than half of the denials were grouped into two MDCs: circulatory system and digestive system.**
 - Circulatory system diagnoses (MDC 05) account for 36 percent of denials.
 - Digestive system diagnoses (MDC 06) account for 16 percent of denials.



Table 5: Top Circulatory System Diagnoses (MDC 05) Denied

Number of denials	Principal diagnosis code	Description
133	I480	Paroxysmal atrial fibrillation
114	R55	Syncope and collapse
99	I4891	Unspecified atrial fibrillation
73	R0789	Other chest pain
51	R079	Chest pain, unspecified
34	I951	Orthostatic hypotension
32	I471	Supraventricular tachycardia
31	I2510	Atherosclerotic heart disease of native coronary artery without angina pectoris
29	I25110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
27	I110	Hypertensive heart disease with heart failure
25	R001	Bradycardia, unspecified
23	I4892	Unspecified atrial flutter
18	I160	Hypertensive urgency
16	I952	Hypotension due to drugs
15	I25119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
15	I4819	Other persistent atrial fibrillation
12	I130	Hypertensive heart and chronic kidney disease with heart failure
10	I214	NSTEMI
10	I442	Atrioventricular block, complete
10	I472	Ventricular tachycardia

Table 6: Top Digestive System Diagnoses (MDC 06) Denied

Number of denials	Principal diagnosis code	Description
56	K529	Noninfective gastroenteritis and colitis, unspecified
44	K219	Gastro-esophageal reflux disease without esophagitis
23	I4892	Unspecified atrial flutter
21	K5900	Constipation, unspecified
17	R109	Unspecified abdominal pain
13	K2970	Gastritis, unspecified, without bleeding
12	A084	Viral intestinal infection, unspecified
11	K921	Melena
11	K922	Gastrointestinal hemorrhage, unspecified
11	R112	Nausea with vomiting, unspecified
10	A09	Other gastroenteritis and colitis of infectious and unspecified origin

Provider Sampling

- **How big is a sample?**
 - A provider sample consists of at least 30 claims which can serve as a basis for improvement measures.
- **Future sampling plans based on findings from the first year of reviews:**
 - Future monthly samples will include some intensive provider samples to focus individual provider education on the proper application of the Two-Midnight Rule.

Best Practices for Claim Approval

- **Documentation of the treating physician's reasoning supporting inpatient admission is critical.**
 - Patient-specific documentation should be included in the medical record to support the reason(s) for inpatient admission.
- **Practitioners should provide clear documentation of the factors that support the two-midnight expectation or the need for inpatient care absent a two-midnight expectation.**
 - Patient-specific documentation will help Livanta clearly understand the physician's reasoning without needing to infer this reasoning.

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.

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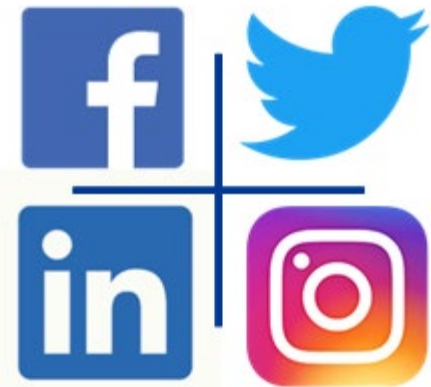
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