February 2023

# THE LIVANTA CLAIMS REVIEW ADVISOR

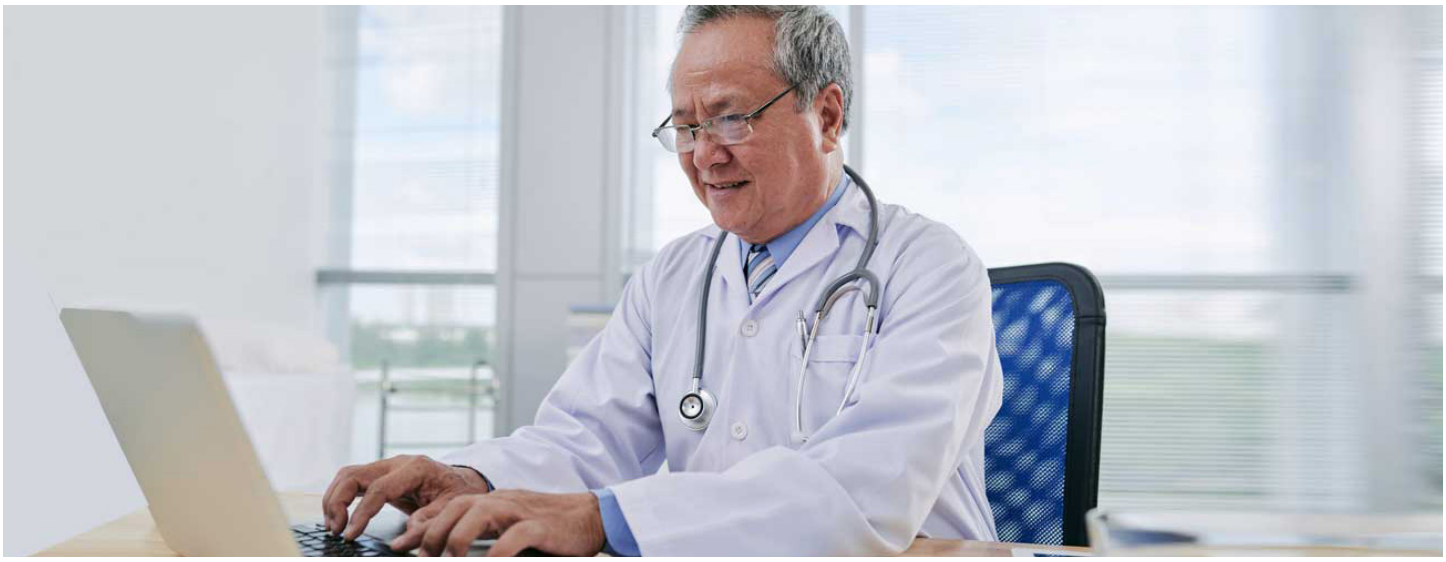
*A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services*

**Volume 2, Issue 1** www.LivantaQIO.com Open in browser

## Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – First Year Review Findings

This month's issue of The Livanta Claims Review Advisor reports on findings from the first year of reviews under Livanta's national Claim Review Services. Medicare HWDRG reviews were paused in May 2019 and resumed in September 2021.

Submitting an adjustment to a Medicare Part A claim that results in a higher-weighted DRG code is a trigger for a potential review of that adjusted claim. This post-pay 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. HWDRG claim reviews encompass two decisions: medical necessity of the inpatient admission and DRG validation. Post-payment review of these HWDRG adjustments is mandated under statute and instruction from the Centers for Medicare & Medicaid Services (CMS) as quoted in the CMS Quality Improvement Organization (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))."
Source:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf



At Livanta, HWDRG reviews are two-pronged: claims are validated by coding auditors and reviewed clinically by physicians as appropriate. Livanta's coding auditors validate the DRGs based on the documentation, official coding guidelines from the American Hospital Association (AHA) Coding Clinics, and other authoritative coding references. Livanta's credentialed auditors adhere to the accepted principles of coding practice to validate the accuracy of the hospital codes that affect the DRG payment. Audits also may involve a clinical review by actively practicing physician reviewers. These physician reviewers determine the clinical validity of physician queries, documented diagnoses and procedures, and the medical necessity of the inpatient admissions. Livanta's rejections of requested HWDRGs can result from either coding audits, physician reviews, or both.

Livanta's CMS-approved sampling strategy for HWDRG claims is described in the June 2022 edition of this newsletter, which can be found here:
https://www.livantaqio.com/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_June.pdf

## Overall Findings

After review, 88 percent of HWDRG claims were approved for the higher-weighted DRG submitted.

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

## 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 were reviewed by Livanta physician reviewers and involve a lack of evidence to support the diagnosis represented by the code.

| Disagreement Reason | Number | Percent |
|---|---|---|
| Clinical | 4,804 | 43% |
| Technical | 6,480 | 57% |
| Total Codes in Disagreement | 11,284 | 100% |

Most code disagreements were technical in nature and involved inappropriate sequencing or lack of documentation found to support an added diagnosis that changed the DRG.

## Findings by CMS Region

These regional findings are based on claims sampled and reviewed in accordance with the CMS-approved sampling strategy as outlined in the June 2022 edition of this newsletter and referenced above.

| CMS Region | DRGs Changed | Claims Reviewed | Regional 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%** |

**Region 1 - Boston**
- Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

**Region 2 - New York**
- New Jersey, New York, Puerto Rico, and the Virgin Islands

**Region 3 - Philadelphia**
- Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

**Region 4 - Atlanta**
- Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

**Region 5 - Chicago**
- Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

**Region 6 - Dallas**
- Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

**Region 7 - Kansas City**
- Iowa, Kansas, Missouri, and Nebraska

**Region 8 - Denver**
- Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

**Region 9 - San Francisco**
- Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshall Islands, and Republic of Palau

**Region 10 - Seattle**
- Alaska, Idaho, Oregon, and Washington

## Reasons for DRG Change by Livanta

| 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% |

The most frequent reasons for DRG errors, as noted in the table above, are:

- Changing the principal diagnosis and/or finding no documentation in the medical record to support an added diagnosis (61 percent, combined).
- The principal diagnosis did not meet the accepted definition (17 percent).

## Reversed HWDRGs

| 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 | Infections and Parasitic Diseases with OR Procedurew with MCC | 111 |
| 640 | Miscellaneous Disorders of Nutrition Metabolism Fluids and Electrolytes | 107 |
| 689 | Kidney and Urinary Tract Infections with MCC | 106 |
| 64 | Intracranial Hemorrhage or Cerebral Infarction with MCC | 76 |
| 291 | Heart Failure and Shock with MCC | 70 |
| 193 | Simple Pneumonia and Pleurisy with MCC | 68 |

As seen in the table above, about two-thirds (66 percent) of the DRG errors reversed the HWDRG to the previously billed DRG

## Top Reasons for Denial


1. Selection of a principal diagnosis that is not supported by the medical record and coding guidelines
   - Did you miss the April 2022 Livanta Claims Review Advisor related to principal diagnosis? Click here to catch up: https://www.livantaqio.com/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_April.pdf

2. 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

     - Read Livanta's August 2022 publication on sepsis: https://www.livantaqio.com/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_August_2022.pdf
     - Read Livanta's October 2022 publication on encephalopathy https://www.livantaqio.com/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_October_2022.pdf

3. Inappropriate query submissions and unsupported responses
   - Did you miss the February 2022 Livanta Claims Review Advisor related to physician queries? Click here to catch up:

https://www.livantaqio.com/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_February.pdf

## Top DRGs Changed

| 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 | 1,074 | 2% |
| 640 | 143 | 867 | 2% |
| 689 | 128 | 652 | 2% |
| 291 | 117 | 1,577 | 2% |
| 64 | 99 | 893 | 2% |

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.

## Focused Training

Based on HWDRG claim reviews conducted by Livanta, many hospitals could benefit from focused training on proper documentation and coding guidelines. Accurate coding based on the coding conventions and guidelines, along with thorough documentation in the medical record, helps ensure proper claim submission and payment.

Please contact Livanta at Claimreview@Livanta.com if your hospital is interested in focused training on specific coding topics.

## 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 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.
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