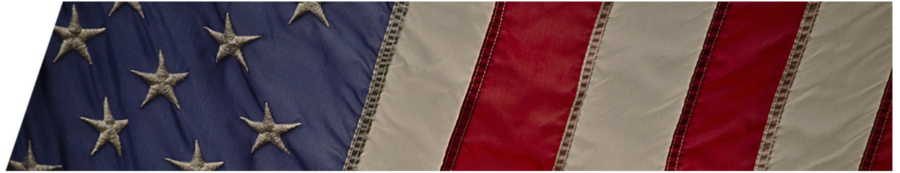
February 2024

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 25 www.LivantaQIO.com Open in browser

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

Background

This month's issue of The Livanta Claims Review Advisor reports on findings from the second year of reviews under Livanta's national Claim Review Services contract. Results for the second year encompass reviews completed from November 1, 2022 through October 31, 2023.

Adjustments submitted to a Medicare Part A claim that result in a higher-weighted DRG code triggers a potential review of that adjusted claim. This post-pay review ensures that the patient's diagnostic, procedural, and discharge information is coded and reported properly on the hospital's claim as compared to documentation in the medical record. HWDRG claim reviews entails two decisions: medical necessity of the inpatient admission and DRG validation.

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

HWDRG reviews involve validation of codes on the claim by credentialed coding auditors and clinical review by board-certified practicing physicians as appropriate. Livanta's coding auditors validate the DRGs based on the documentation in the medical record, using official coding guidelines, 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 2023 edition of this newsletter, which can be found here:
https://www.livantaqio.cms.gov/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_June_2023.pdf

Overall Findings

After review, 88 percent of HWDRG claims were approved for the higher-weighted DRG submitted and paid. Again, results for the second year encompass reviews completed from November 1, 2022 through October 31, 20231.

Description	Number	Percent
Approved	50,928	88%
DRG Changes	6,603	11%
Admission Denials	619	1%
Total Claims Reviewed	58,150	100%

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 2023 edition of this newsletter and referenced above.

Medical necessity errors were all due to failure to meet the guidelines of the Two-Midnight Rule.

CMS Region	# Claims Reviewed	# HWDRGs Changed	# Medical Necessity Errors	# Total Errors	Regional Error Rate	Region's Contribution to Total Errors
1	1,664	179	13	192	12%	3%
2	2,101	140	13	153	7%	2%
3	3,951	410	44	454	11%	6%
4	20,210	2,717	274	2,991	15%	41%
5	4,837	369	47	416	9%	6%
6	11,130	1,415	109	1,524	14%	21%
7	2,908	278	25	303	10%	4%
8	1,543	162	21	183	12%	3%
9	8,090	821	62	883	11%	12%
10	1,716	112	11	123	7%	2%
Total	**58,150**	**6,603**	**619**	**7,222**	**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 U.S. 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

Code Level Changes

DRG changes occur at the individual code level. Coding errors are classified as either technical or clinical errors.

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

Disagreement Reason	Number	Percent
Clinical	4,711	40%
Technical	7,034	60%
Total Codes in Disagreement	11,745	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.

Reasons for DRG Change by Livanta

Error Classification	Count of Codes	Percent in Error
No Documentation of Diagnosis	3,955	37%
Changed Principal Diagnosis	3,288	30%
Principal Diagnosis Re-sequenced	1,687	16%
Incorrect Diagnosis Code	670	6%
Specificity of Diagnosis Code	529	5%
Missed Diagnosis Code	302	3%
No Documentation of Procedure	188	2%
Incorrect Procedure Code	83	1%
Specificity of Procedure Code	42	0%
Missed Procedure Code	43	0%

The most frequent reasons for HWDRG 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 (67 percent, combined).
- The principal diagnosis did not meet the accepted definition (16 percent).

Reversed HWDRGs

The table below shows the top 10 DRGs that resulted in Livanta reversing the HWDRG to the previously billed DRG.

HWDRG	Description	# Claims Changed to Prior DRG
690	Kidney and urinary tract infections without MCC	258
193	Simple pneumonia and pleurisy with MCC	220
378	G.I. hemorrhage with CC	197
683	Renal failure with CC	177
872	Septicemia or severe sepsis without MV >96 hours without MCC	150
291	Heart failure and shock with MCC	138
641	Miscellaneous disorders of nutrition, metabolism, fluids and electrolytes without MCC	137
689	Kidney and urinary tract infections with MCC	133
194	Simple pneumonia and pleurisy with CC	120
065	Intracranial hemorrhage or cerebral infarction with CC or tPA in 24 hours	115
603	Cellulitis without MCC	103
682	Renal failure with MCC	103

Overall, 4,438 HWDRGs (67 percent) were reversed to the previously billed DRG based on the documentation submitted in the medical record to support the HWDRG claim.

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

Read Livanta's April 2023 publication on malnutrition:
https://www.livantaqio.cms.gov/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_April_2023.pdf

3. Inappropriate query submissions and unsupported responses.

Did you miss the latest December 2023 Livanta Claims Review Advisor related to physician queries? Click here to catch up:
https://www.livantaqio.cms.gov/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_December_2023.pdf

Top HWDRGs Changed

The top 10 HWDRGs found to be in error are noted in the table below.

HWDRG	# HWDRGs Changed	# Claims Reviewed	DRGs Contribution to Total DRG Changes
872	1,536	399	26%
811	1,737	412	24%
871	10,812	2,459	23%
689	1,540	274	18%
682	3,891	670	17%
640	1,977	310	16%
853	2,235	274	12%
064	2,004	233	12%
193	2,299	252	11%
291	3,234	219	7%

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 e-mail 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** or visit the claim review website for more information:
https://www.livantaqio.cms.gov/en/ClaimReview/index.html

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