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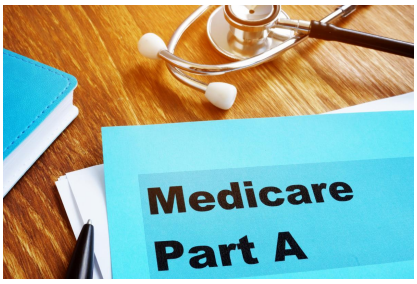
Higher-Weighted Diagnosis Related Groups (HWDRG) Validation – Third Year Review Findings



This month's issue of *The Livanta Claims Review Advisor* reports findings from the third year of reviews under Livanta's national Claim Review Services contract. Results for the third year encompass reviews completed from November 1, 2023 through October 31, 2024.

An adjustment submitted to a Medicare Part A claim that results 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 correctly on the hospital's claim compared to documentation in the medical record. HWDRG claim reviews entail two decisions: the 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 April 2024 edition of this newsletter, which can be found here: **https://www.livantaqio.cms.gov/en/ClaimReview/files/The_Livanta_Claims_Review_Advisor_April_2024.pdf**

Overall Findings

Review Type/Year	Total Reviews	Claims in Error	% Claims in Error
HWDRG Year 1	54,251	6,636	12%
HWDRG Year 2	58,150	7,222	12%
HWDRG Year 3	57,636	6,447	11%

After review, 89 percent of HWDRG claims reviewed by Livanta were approved for the higher-weighted DRG that had been submitted and paid. For those found to be in error in Year 3, the breakout is below. Admission denials were all due to failure to meet the guidelines of the Two-Midnight Rule.

Description	Number	Percent
Approved	51,189	89%
DRG Changes	5,744	10%
Admission Denials	703	1%
Total Claims Reviewed	57,636	100%

Year 3 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 April 2024 edition of this newsletter and referenced above.

CMS Region	# Claims Reviewed	#HWDRGs Changed	# Medical Necessity Errors	# Total Errors	Regional Error Rate	Region's Contribution to Total Errors
1	1,780	204	23	227	13%	4%
2	2,670	162	11	173	6%	3%
3	3,589	277	47	324	9%	5%
4	19,001	2,243	323	2,566	14%	40%
5	5,640	355	49	404	7%	6%
6	9,990	1,210	146	1,356	14%	21%
7	2,471	198	22	220	9%	3%
8	1,669	117	16	133	8%	2%
9	8,900	861	48	909	10%	14%
10	1,926	117	18	135	7%	2%
Total	57,636	5,744	703	6,447	11%	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

Year 3 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	4,740	53%
Technical	4,192	47%
Total Codes in Disagreement	8,932	100%

Most code disagreements were clinical in nature, and Livanta's physician reviewers did not find evidence in the documentation to support the diagnosis that was added to the claim.

Reasons for DRG Change by Livanta

Error Classification	Count of Codes	Percent in Error
No Documentation of Diagnosis	3,182	36%
Changed Principal Diagnosis	2,295	26%
Incorrect Diagnosis Code	1,310	15%
Principal Diagnosis Re-sequenced	1,033	12%
Specificity of Diagnosis Code	546	6%
Missed Diagnosis Code	211	2%
No Documentation of Procedure	183	2%
Incorrect Procedure Code	86	1%
Specificity of Procedure Code	58	1%
Missed Procedure Code	28	0%
	8,932	100%

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 (62 percent, combined).
- The principal diagnosis did not meet the accepted definition, and/or an added diagnosis code was incorrect (27 percent, combined).

Reversed HWDRGs

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

HWGRG	Description
871	Septicemia or severe sepsis without MV >96 hours with MCC
682	Renal failure with MCC
872	Septicemia or severe sepsis without MV >96 hours without MCC
689	Kidney and urinary tract infections with MCC
064	Intracranial hemorrhage or cerebral infarction with MCC
811	Red Blood Cell Disorders with MCC
640	Misc. Disorders of Nutrition, Metabolism, Fluids and Electrolytes with MCC
193	Simple pneumonia and pleurisy with MCC
853	Infectious and Parasitic Diseases with OR Procedures with MCC
177	Respiratory Infections and Inflammations with MCC

Overall, 68 percent of HWDRGs found in error 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	DRG Error Rate
872	513	2,043	25%
871	3,371	16,043	21%
689	425	2,291	19%
811	462	2,563	18%
682	946	5,537	17%
637	196	1,205	16%
391	244	1,597	15%
056	197	1,335	15%
640	454	3,103	15%
064	394	3,009	13%

Sepsis DRGs (871 and 872) together account for nearly half (46%) of the DRGs found to be in error.

Focused Training

Based on Livanta's HWDRG claim reviews, hospitals could benefit from focused training on proper documentation and coding guidelines. Accurate coding based on the coding conventions and guidelines and 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 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