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THE LIVANTA CLAIMS REVIEW ADVISOR

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Higher-Weighted DRG Review – Sampling Strategy

Decreasing Medicare's Paid Claims Error Rate

A primary objective of the Medicare claim review services contract is to work toward decreasing Medicare's paid claims error rate and protecting the Medicare Trust Fund. Livanta developed the Improper Payment Reduction Strategy (IPRS) as a tool to accomplish this important objective. The IPRS outlines the strategy Livanta uses to sample claims for higher-weighted diagnosis related group (HWDRG) reviews. As a living document, Livanta updates the IPRS annually and incorporates empirical findings from the HWDRG reviews finalized during the previous year.

BFCC-QIO Authority to Conduct Claim Review

A hospital reimbursed under the Centers for Medicare & Medicaid (CMS) Inpatient Prospective Payment System (IPPS) may request HWDRG payment when the hospital determines that the clinical circumstances of the case warrant a claim correction that results in payment of a higher-weighted Medicare Severity DRG (MS-DRG), which increases the reimbursement to the hospital. By de inition, HWDRGs are adjusted claims for which the hospital is seeking a higher payment amount than was previously submitted. Post-payment review of these HWDRG adjustments is mandated under statute and CMS instruction as quoted in the CMS QIO Manual:
Perform DRG validation on 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)). 42 CFR 476.71.

Livanta devised a flexible approach to sampling that could accommodate monthly fluctuations in HWDRG claims for potential selection and review, as outlined in the CMS-approved IPRS. The goal of this approach is to sample and review HWDRG claims in a manner that is more likely to uncover errors than would a purely random sample, while still being able to reconstruct justifiable regional and national improper payment amounts for all paid HWDRG claims.

HWDRG Sampling Strategy and Claims Weighting

As noted above, Livanta's recently updated IPRS was informed by completed HWDRG reviews. The prior year of completed HWDRG reviews provided actual data to move into evidence-based sampling. This approach applies the use of historical data to identify diagnosis related groups (DRGs) most likely to be paid in error. The details of the methodology are described below.

To begin, Livanta downloads all eligible HWDRG adjustments from the CMS claims database each month. Each claim is prioritized for sampling according to its cost, representative frequency, and clinical likelihood of an improper payment. This prioritization process forms an improper payment risk score that is used during sample selection.

All samples are assessed at the stratum (risk score) level to assure their statistical independence, along with their representativeness for both information content and typical values. This sample validation process, using statistically valid quality assurance tests, firmly establishes the reliability and the validity of the results found from the samples.[1]

[1] Allen, M. & Yen, W. (1979). Introduction to Measurement Theory 1st Edition, p. 75. ISBN-13: 978-0818502835.

Sampling Prioritization Scores

In keeping with its IPRS, Livanta applies a three-part prioritization scoring methodology to HWDRG claims, given that a sufficient number of eligible claims are available for any given month to conduct sampling. The three components that are individually scored are volume, clinical risk of improper payment, and cost for each HWDRG adjusted claim. The individual scores are added together to assign a risk weight for each HWDRG claim eligible for sampling. Claims with higher computed risk scores are sampled at a higher rate than lower risk-score claims. The individual risk score components are analyzed and adjusted as needed based on ongoing review outcomes.

Table 1: HWDRG Compensatory Score

Component	Score = 1	Score = 2	Score = 3
Volume by DRG	Low Volume DRGs	Medium Volume DRGs	High Volume DRGs
Clinical Risk	Low Risk by DRG	Medium Risk by DRG	High Risk by DRG
Cost by DRG	Low Cost by DRG	Medium Cost by DRG	High Cost by DRG

Sampling Components

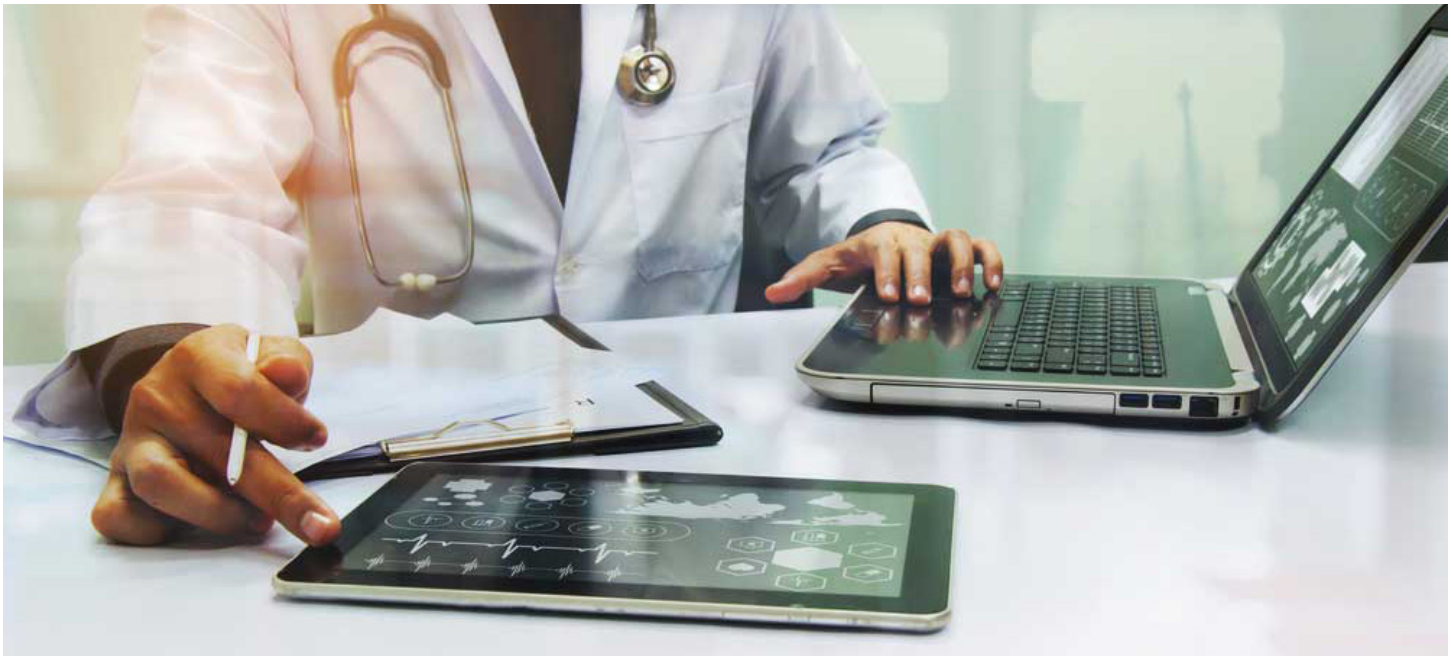
- Volume by DRG – HWDRGs on the adjusted claim are sorted by volume and scored accordingly
- Clinical risk – analysis of the DRGs most often denied informed this category for ranking the DRGs as high, medium, or low risk of improper payment
- Cost by DRG – HWDRG claims are sorted by cost and scored accordingly

Sample and Extrapolation Adjustments

Unless the total listing of eligible claims (the population) is sufficiently large, there will be times when the allocated number of claims for each stratum will not be met by the number of claims that are eligible for sampling from the designated strata. Under those conditions, the additional claims are selected from the higher priority strata, in concert with the stated goals of the IPRS.

Technical denials are issued when a medical record has not been received for review in a timely manner. Technical denials are counted in the regional and national estimates as if the claims were reviewed and found to be improperly paid. Although the subsequent submission of the needed documentation may reverse the technical denial, these denials can be avoided by submitting the supporting documentation upon request.

Individualized Hospital Results



When a hospital has had at least 30 claims sampled and reviewed in a monthly sample, those claims are aggregated to form a hospital-specific report that is sent to the hospital. The report summarizes information the hospital has already received during the course of the monthly claims review process and includes identified areas for educational intervention where findings warrant. For subsequent hospital reports, only aggregates of at least 30 newer claims will be used and presented such that information about errors is allowed to age out of each hospital-based report.

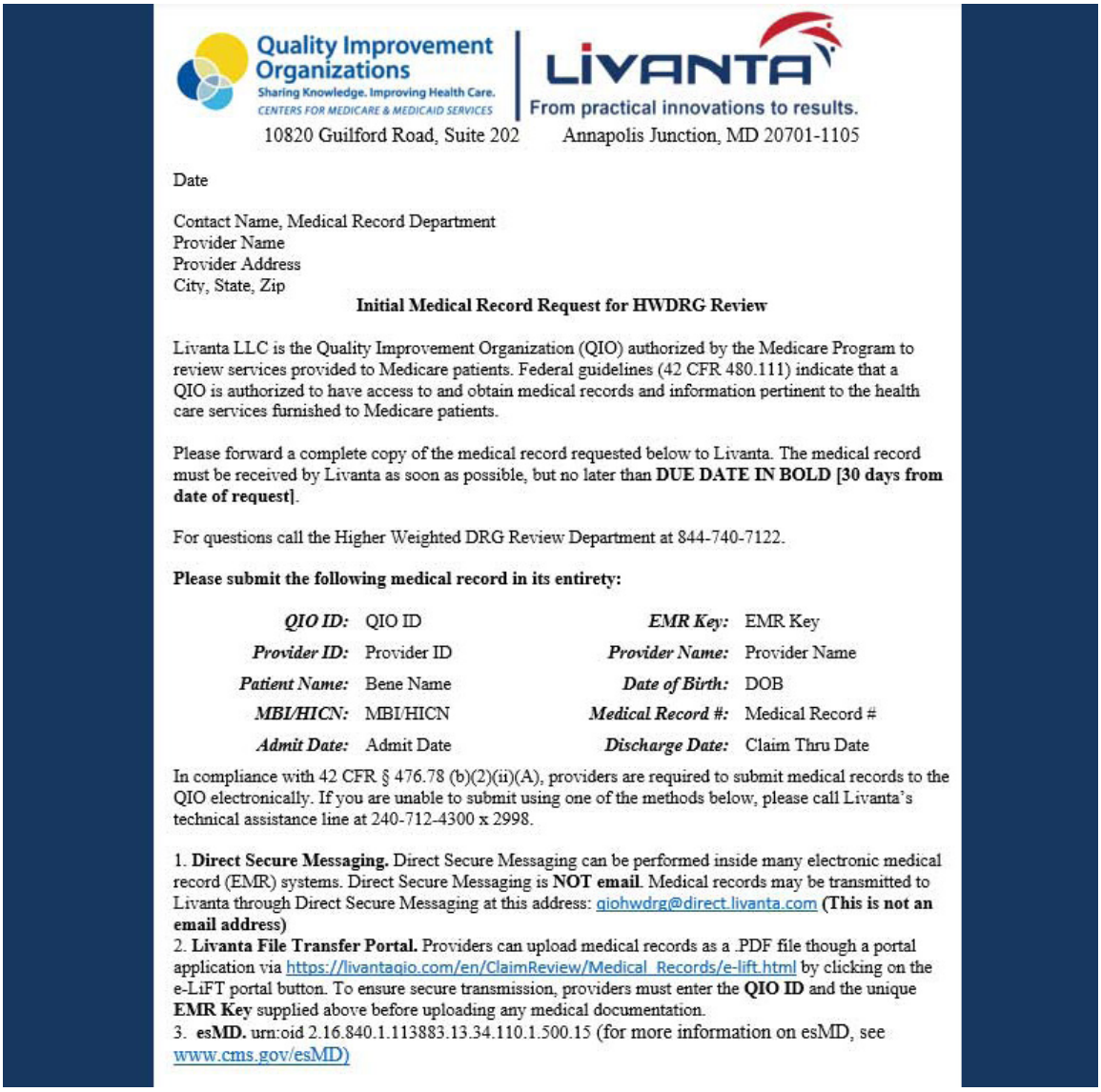
What Can Hospitals Expect?

Hospitals can expect to receive medical record requests by fax or mail for sampled short stay claims at the beginning of each month. These sampled claims will be reviewed for the appropriateness of inpatient admission under Medicare's Two-Midnight Rule. The greater the number of short stay claims that a hospital submits, the higher the likelihood that some of their claims will be sampled and reviewed.

These requests will be addressed to the medical record contact the hospital has designated in the Memorandum of Agreement (MOA) effectuated with Livanta. If a hospital has multiple claims sampled in a month, the medical record requests will be transmitted in one package.

The dates hospitals can expect to see SSR medical record requests are published on Livanta's website:
https://livantaqio.com/en/ClaimReview/Review_Types/ssr.html
An example SSR record request template is shown below so that hospitals become familiar with identifying them.

Figure 1: Example HWDRG Record Request



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From practical innovations to results.

10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105

Date

Contact Name, Medical Record Department
Provider Name
Provider Address
City, State, Zip

Initial Medical Record Request for HWDRG Review

Livanta LLC is the Quality Improvement Organization (QIO) authorized by the Medicare Program to review services provided to Medicare patients. Federal guidelines (42 CFR 480.111) indicate that a QIO is authorized to have access to and obtain medical records and information pertinent to the health care services furnished to Medicare patients.

Please forward a complete copy of the medical record requested below to Livanta. The medical record must be received by Livanta as soon as possible, but no later than **DUE DATE IN BOLD [30 days from date of request]**.

For questions call the Higher Weighted DRG Review Department at 844-740-7122.

Please submit the following medical record in its entirety:

QIO ID:	QIO ID	***EMR Key:***	EMR Key
Provider ID:	Provider ID	***Provider Name:***	Provider Name
Patient Name:	Bene Name	***Date of Birth:***	DOB
MBI/HICN:	MBI/HICN	***Medical Record #:***	Medical Record #
Admit Date:	Admit Date	***Discharge Date:***	Claim Thru Date

In compliance with 42 CFR § 476.78 (b)(2)(ii)(A), providers are required to submit medical records to the QIO electronically. If you are unable to submit using one of the methods below, please call Livanta's technical assistance line at 240-712-4300 x 2998.

1. **Direct Secure Messaging.** Direct Secure Messaging can be performed inside many electronic medical record (EMR) systems. Direct Secure Messaging is **NOT email**. Medical records may be transmitted to Livanta through Direct Secure Messaging at this address: qiohwdrg@direct.livanta.com **(This is not an email address)**
2. **Livanta File Transfer Portal.** Providers can upload medical records as a .PDF file though a portal application via https://livantaqio.com/en/ClaimReview/Medical_Records/e-lift.html by clicking on the e-LiFT portal button. To ensure secure transmission, providers must enter the **QIO ID** and the unique **EMR Key** supplied above before uploading any medical documentation.
3. **esMD.** urn:oid 2.16.840.1.113883.13.34.110.1.500.15 (for more information on esMD, see www.cms.gov/esMD)

Questions?

Should you have questions, please email
ClaimReview@Livanta.com

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