

Orientation for Livanta's Claim Review Services for the Centers for Medicare & Medicaid Services (CMS)



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Objectives

During this webinar, participants will:

1. Discuss Livanta's role as a Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) for Medicare case review and claim review.
2. Review the importance of the Memorandum of Agreement (MOA).
3. Introduce Livanta's Improper Payment Reduction Strategy (IPRS).
4. Review key provider action items for Medicare compliance.

Disclaimer

1. This presentation is geared toward Livanta's claim review services for hospitals.

- Claim review includes short stay and higher weighted diagnosis related group.
- Case review includes discharge and service termination appeals and quality of care reviews.

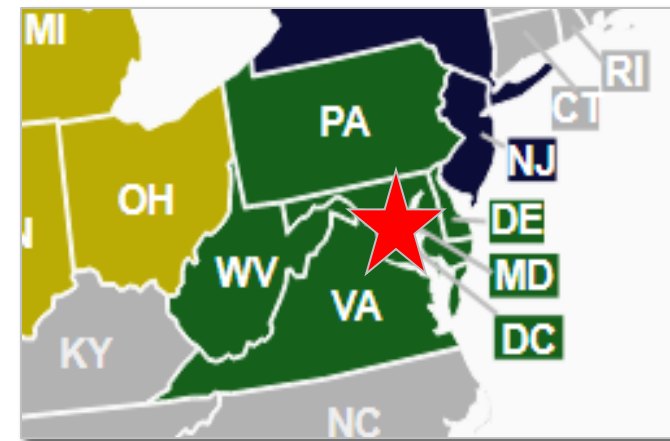
2. Unless specifically noted, information and guidance pertaining to Livanta's case review is unchanged.

3. Refer to Livanta's website for current information.

- Case Review for CMS Regions 2, 3, 5, 7, and 9:
<https://LivantaQIO.com/en>
- Claim Review for all 10 CMS Regions:
<https://LivantaQIO.com/en/ClaimReview>

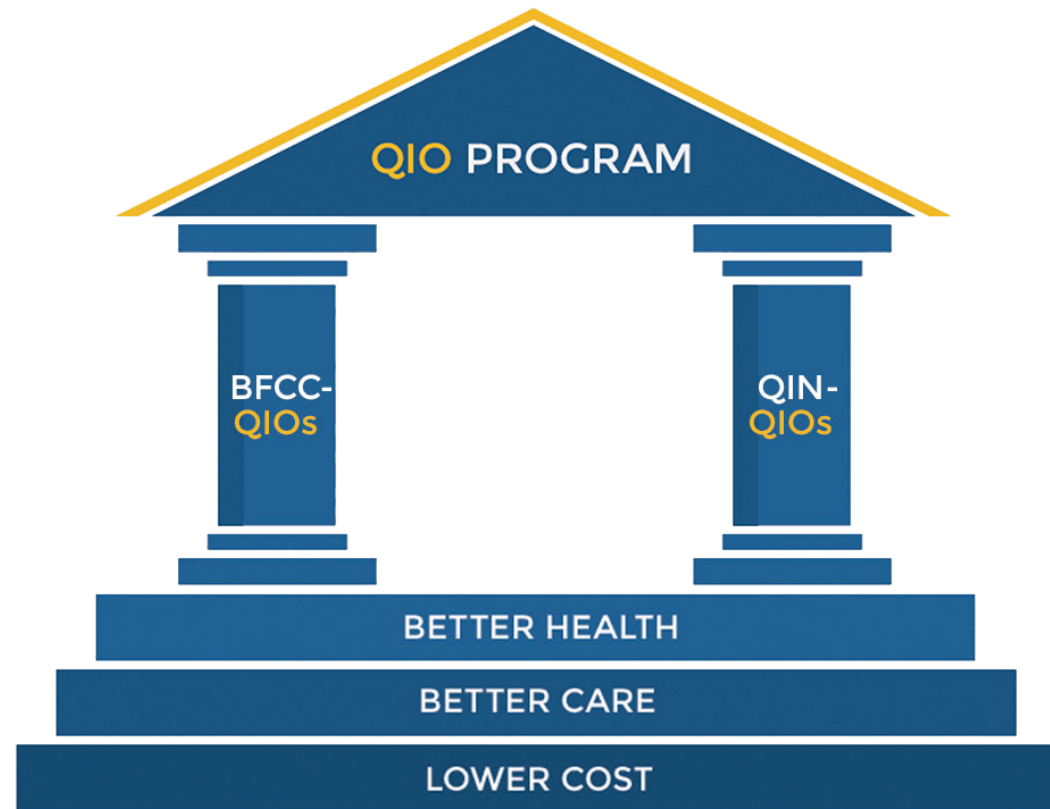
About Livanta LLC

- **Established in 2004**
- **Privately-held, government contracting firm**
- **Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO)**
- **BFCC-QIO since 2014**
 - 11th Statement of Work: 2014-2019
 - 12th Statement of Work: 2019-2024
- **Current CMS Contracts**
 - Case Review: CMS Regions 2, 3, 5, 7, and 9
 - Claim Review: Nation-wide



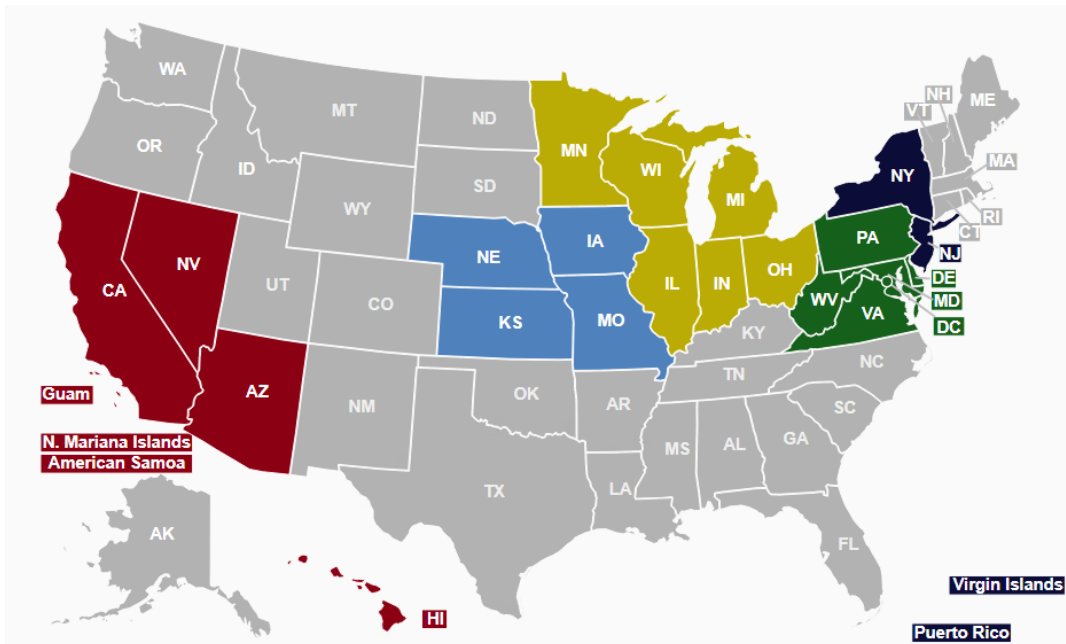
The QIO Program Structure

- The QIO Program is one of the largest federal programs dedicated to improving health quality at the local level.
- The QIOs are the bridge between patients, providers, and CMS.
- The QIOs are your partners in the delivery of quality healthcare and positive health outcomes.



Medicare Case Review Services

- Two BFCC-QIOs manage appeals of discharge and termination of services, quality of care reviews, Emergency Medical Treatment and Labor Act (EMTALA), and other case reviews.

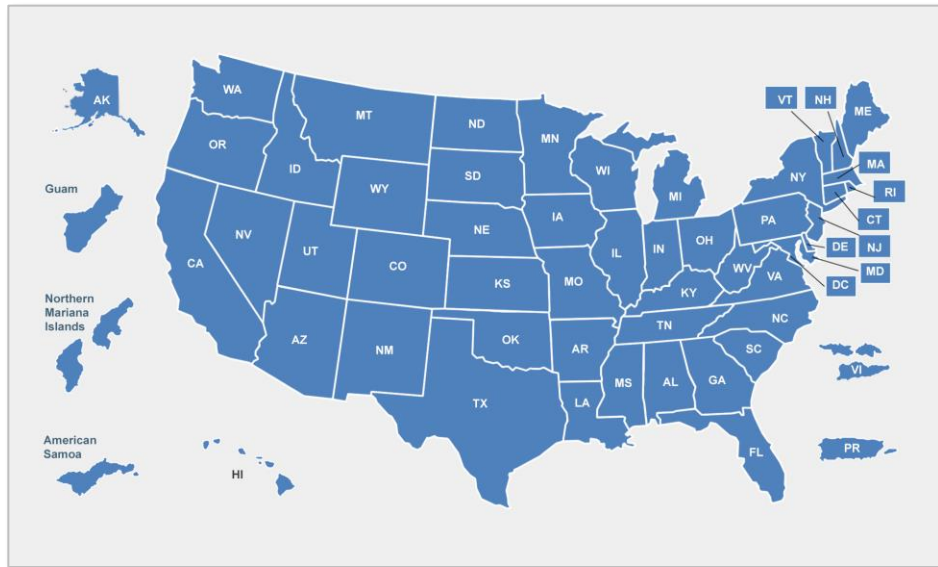


-  Livanta: Region 2
-  Livanta: Region 3
-  Livanta: Region 5
-  Livanta: Region 7
-  Livanta: Region 9
-  KEPRO

Locate your QIO at <http://www.qioprogram.org/locate-your-qio>

Medicare Claim Review Services

- As a BFCC-QIO, Livanta was awarded this national contract to review hospital claims for short stays and higher weighted diagnosis-related groups.
- Expected outcome: to decrease the CMS paid claims error rate through medical review of coverage, coding, and billing errors.



■ Livanta:
All states and territories.

Getting Started: What Does My Hospital Need to Know?

MOA: Each hospital must sign a Memorandum of Agreement (MOA) with Livanta and maintain accurate points of contact.

IPRS: Livanta's Improper Payment Reduction Strategy outlines the sampling plan and educational outreach for short stay reviews (SSRs) and higher weight diagnosis related group (HWDRG) reviews.

Claim Review: Medical records for SSRs and HWDRG reviews will be requested monthly for sampled claims.

Electronic Submission: Medical records, when requested, must be submitted electronically.

Stay in Touch

Livanta sends out periodic Provider Bulletins to the provider community.



Memorandum of Agreement (MOA)

Memorandum of Agreement (MOA) with BFCC-QIOs

Who needs an MOA with Livanta?

- Acute care hospitals in all CMS regions. Includes critical access hospitals, inpatient psychiatric hospitals, long-term acute care (LTAC) hospitals.
- Skilled nursing facilities, home health agencies, hospices, and comprehensive outpatient rehabilitation facilities in CMS Regions 2, 3, 5, 7, and 9.

MOA

Do I need an MOA with Kepro?

- For case review purposes, providers located in CMS Regions 1, 4, 6, 8, and 10 may need an MOA with Kepro in addition to any MOA required with Livanta. Check Kepro's website, www.keproqio.com for more information.

The Criticality of the MOA

Livanta will communicate with the named individuals on each hospital's MOA.

- Medical Records Requests Contact
- General QIO Liaison
- QIO Remittance Contact

MOA

In the absence of an MOA and updated contact information, Livanta will use the information in the CMS Program Resource System (PRS).

- PRS data may be outdated.
- Livanta will communicate via the USPS if a valid fax number is not available.

Note:

Not all hospitals in the nation will receive medical record requests every month.

MOA Regulatory Compliance

QIO Manual

- The QIO Manual stipulates that QIOs review the validity of diagnostic information provided, the appropriateness of admissions and discharges, and the appropriateness of care provided with respect to services for which payment may be made under Part A of Medicare, along with the case review activities of appeal reviews and quality of care reviews.

MOA

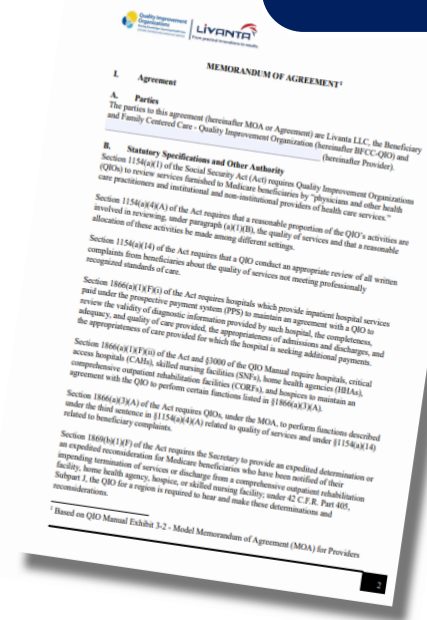
Code of Federal Regulations (42 CFR 489.20[e])

- In the case of a hospital or critical access hospital (CAH) that furnishes inpatient hospital services or inpatient CAH services for which payment may be made under Medicare, to maintain an agreement with a QIO for that organization to review the admissions, quality, appropriateness, and diagnostic information related to those inpatient services.

Memorandum of Agreement (MOA) Points of Contact with Livanta

- **CMS Regions 2, 3, 5, 7, and 9**
 - QIO Appeal Cases Contact
 - Medical Records Contact for Case Review types other than Appeals
 - General QIO Liaison
 - QIO Remittance Contact
- **CMS Regions 1, 4, 6, 8, and 10**
 - Medical Records Requests Contact
 - General QIO Liaison
 - QIO Remittance Contact

MOA



Improper Payment Reduction Strategy (IPRS)

Improper Payment Reduction Strategy

The BFCC-QIO shall work towards decreasing the Agency's paid claims error rate. To assist in this effort, the QIO has developed an Improper Payment Reduction Strategy or IPRS. The IPRS was approved by CMS and outlines the sampling strategy for SSR and HWDRG claims.

- Each month, the QIO downloads eligible paid claims for both SSR and HWDRG from the CMS database.
- Each claim is then 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.

IPRS

IPRS Claim Scoring

For 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.

For 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.

For Clinical Risk

- All DRGs have been ranked using environmental scans as a starting point.
- Each DRG is scored from most (3) to least (1) clinical risk impact.

IPRS

IPRS Final Claim Score

All 3 scores from the previous slide are added to the claim by DRG and summed for the Final IPRS Claim Score*

***SSR has one additional score for claim Length of Stay:**

- 0-day LOS is scored higher (2), and 1-day LOS is scored lower (1).
- LOS score is calculated for SSR claims, and all 4 scores are summed for the Final IPRS Claim Score.

IPRS

National Sampling

Samples of individual claims are drawn from the downloaded eligible paid claims each month: one for HWDRG and one for SSR.

IPRS

- The claim universes are stratified by Final IPRS Claim Score and then randomly sampled according to the Statistician's sampling plan (number of claims in sample, oversamples, count by score, etc.).
- These samples are validated for representativeness by Livanta's statistician.
- Each sampled claim will be reviewed once the associated medical record is received, and results communicated to the hospital at the individual claim level.

Provider Samples

A Provider Sample consists of a minimum of 30 sampled claims for an individual provider.

- Reports will be issued for Provider Samples summarizing the results of the sampled claims.
- If an issue is identified that may lend itself to educational intervention, a 1:1 provider education session will be scheduled with the provider to assist them with the submission of claims for proper payment.

IPRS

Regional Service-Specific Samples

Service-Specific Samples consist of 50 sampled claims for a specific DRG or other service-oriented designation within a CMS Region.

- Reports will be generated for Service-Specific Samples summarizing the results of the sampled claims.
- Livanta will share these summary reports via bulletins, newsletters, and/or webinars. Findings may warrant some general educational opportunities as well.

IPRS

Claim Review

Higher-Weighted Diagnosis Related Group (HWDRG) Reviews

- **HWDRG reviews are post-payment reviews initiated by the hospital with a claim adjustment that results in a DRG change to a higher weight.**
- **HWDRG reviews encompass medical necessity for inpatient admission and DRG validation of the adjusted claim.**
- **The purpose of the DRG validation is to ensure that diagnostic and procedural information and the discharge status of the patient, as coded and reported by the hospital on the claim, match the information contained in the medical record.**

**Claim
Review**

The HWDRG Review Process

Medical Record Requests

- The first medical record requests were sent via fax on 9/3/21 when available and via mail when fax was not available.
- Records must be submitted electronically through esMD, DSM, or e-LiFT. Instructions are on the request and Livanta's claim review website, with a phone number to call for technical assistance.

**Claim
Review**

Determination Letters

- Letters will be sent via fax to the QIO Liaison or mailed if fax is not available. No letter is sent if the claim is fully approved upon first review. Hospitals will have access to a case lookup feature on the Livanta website to obtain findings on sampled claims.
- Before making any correction affecting DRG assignment or medical necessity, the hospital will be provided an opportunity for discussion.
- If the hospital does not respond, the initial findings will be finalized, and the MAC notified of the change. If the change involves denial of inpatient admission, the beneficiary is also notified.
- If the hospital responds to the opportunity for discussion, that response is taken into consideration when making the final determination on the claim.

HWDRG Education

- **Determination letters issued on sampled claims provide educational information regarding the issue affecting payment.**
- **An educational 1:1 teleconference will be scheduled with the hospital when results from a provider sample indicate a need for education, or at the hospital's request.**
- **Hospital samples consist of 30 claims reviewed for an individual hospital and a summary report with all review findings will be issued to the hospital for educational purposes.**

**Claim
Review**

Short Stay Reviews (SSRs)

- **SSR are post-payment reviews of Part A claims for appropriateness of inpatient admission under the CMS Two-Midnight Rule.**
- **Part A claims for which the patient was discharged in less than two midnights from the date of admission are eligible for review.**

**Claim
Review**

The SSR Process

Medical Record Requests

- The first medical record requests will be sent via fax when possible or mail if fax is not available. The timeline is to be announced.
- Records must be submitted electronically through esMD, DSM, or e-LiFT. Instructions are on the request and Livanta's claim review website, with a phone number to call for technical assistance.

**Claim
Review**

Determination Letters

- Letters will be sent via fax to the QIO Liaison or mailed if fax is not available. No letter is sent if the claim is fully approved upon first review. Hospitals will have access to a case lookup feature on the Livanta website to obtain findings on sampled claims.
- Before making any correction denying payment, the hospital will be provided an opportunity for discussion.
- If the hospital does not respond, the initial findings will be made final, and the MAC notified of the denial. The beneficiary is also notified when the admission is denied.
- If the hospital responds to the opportunity for discussion, that response is taken into consideration when making the final determination on the claim.

SSR Education

- **Determination letters issued on sampled claims provide educational information regarding the issue affecting payment.**
- **An educational 1:1 teleconference will be scheduled with the hospital when results from a provider sample indicate a need for education, or at the hospital's request.**
- **Hospital samples consist of 30 claims reviewed for a specific hospital and a summary report with all review findings will be issued to the hospital for educational purposes.**

**Claim
Review**

Electronic Submission



**Quality Improvement
Organizations**
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LIVANTA[™]
From practical innovations to results.[™]

CMS Final Rule 1735-F

- **42 CFR § 476.78 (b)(2)(ii)(A) requires providers to submit medical records to the QIO in electronic format.**
- **In effect since October 1, 2020.**
- **Allows for reimbursement for electronic submission of medical records to the QIO for the first time.**

**Electronic
Submission**

Electronic Medical Record Transmission

- **Livanta accepts electronic submission through:**
 - Livanta's e-LiFT portal
 - Direct Secure Messaging (DSM)
 - esMD Transmission

- **Electronic Format is NOT:**
 - Fax
 - Email

Electronic Submission

The technical assistance hotline is available to hospitals if needed.

240-712-4300 x 2998

9:00 a.m. - 5:00 p.m. Local Time on Weekdays

11:00 a.m. - 3:00 p.m. Local Time on Weekends and Holidays

Options for Electronic Medical Record Submission

- **Livanta's e-LiFT System (Secure upload)**
 - Secure portal found on Livanta's Claim Review website
 - Upload PDF documents easily and securely
- **Direct Secure Messaging**
 - Convenient
 - Future-proof
 - EMR system integration (contact your vendor)
- **esMD**
 - CMS owned and operated system
 - for more information on esMD, see www.cms.gov/esMD

**Electronic
Submission**

Sign up for Provider Bulletins and More

www.LivantaQIO.com/en/About/Publications

Stay in Touch

- **Provider Bulletins (Case Review)**
- **Provider Bulletins (Claim Review)**
- **The Livanta Beacon**
- **The Livanta Compass**
- **The Livanta Ledger**

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- Provider Bulletins - Case Review. Receive critical information about beneficiary case reviews, including discharge and service termination appeals, quality of care complaints, and immediate advocacy.
- Provider Bulletins - Claim Review. Receive critical information about claim review activities, including Short Stay Reviews (SSRs) and Higher-Weighted Diagnosis Related Group (HWDRG) reviews.
- The Livanta Beacon - coming soon! These true-to-life stories of Medicare patients, families, and caregivers show how Immediate Advocacy helps resolve barriers to care, inspiring hope and confidence that those in need can successfully navigate their care.
- The Livanta Compass. Subscribe to our award-winning e-journal for weekly articles that provide insights and updates on important topics for the Medicare community.
- The Livanta Ledger. In this publication, learn about Livanta's success stories and innovative developments regarding our work as a Quality Improvement Organization.

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Livanta Provider Helpline

We are here to answer your questions
Weekdays 8 a.m. - 4:30 p.m. ET

Type of Review	Provider Helpline
Short Stay Reviews	844-743-7570
Higher Weighted DRG Reviews	844-740-7122

Visit us on the web
<https://LivantaQIO.com/en/ClaimReview>

Actions for Providers

- 1) Update internal procedures to include annual MOA review.
- 2) Begin electronic submission of medical records.
- 3) Sign up for Livanta's publications.



Questions?

