Transfer DRGs:
Approaches to Revenue Recovery

A BESLER White Paper

June 2014
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*HFMA staff and volunteers determined that Transfer DRG Revenue Recovery Service has met certain criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this service.
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Executive Summary

The Centers for Medicare and Medicaid Services (CMS) pays for Medicare inpatient hospital care on the basis of Diagnosis Related Groups (DRGs). Certain DRGs (known as Transfer DRGs) are paid under the Medicare Post Acute Care Transfer Rule (Transfer Rule), which reduces payments for hospitals that transfer patients to other providers to continue treatment.

In a significant number of cases, patients are not treated as planned after being transferred, or an inaccurate discharge status code is assigned to the claim. These factors result in an unwarranted reduction in the transferring hospital’s Medicare payment. *The impact to US hospitals is in the hundreds of millions of dollars per year.*

Properly reviewing the post-transfer care that patients receive and identifying underpayment situations can provide hospitals with a significant revenue boost. However, it’s important to identify and address these situations in a manner that is compliant.

This white paper discusses solutions that allow hospitals to recover the revenue they’ve properly earned when they’ve been underpaid due to the Transfer Rule. Many of the issues and solutions discussed in this white paper also apply to Medicare Advantage transfer claims.
Market Drivers

The Transfer Rule

In the 1990s, it became apparent to CMS that certain cases with short hospital stays were being reimbursed at the full DRG rate even though they were being transferred to another healthcare provider to complete treatment and recovery. Because they felt Medicare was paying twice for the treatment of certain patients, CMS officials adopted the Transfer Rule.

For a subset of DRGs, certain transfers with a hospital stay at least one day less than the geometric mean (roughly the average) length of stay for the DRG are paid according to one of two per diem formulas that reduce the discharging hospital’s reimbursement.

In federal fiscal year 1999, there were ten DRGs subject to the Transfer Rule. At that time, the financial impact was minor. However, in subsequent years the number of DRGs impacted by the rule was repeatedly increased, to the point where there are 275 DRGs affected today.

Number of Transfer DRGs by Federal Fiscal Year

![Number of Transfer DRGs by Federal Fiscal Year](chart.png)
Healthcare Reform

Under the Patient Protection and Affordable Care Act of 2010, providers are facing potential Medicare reimbursement reductions at every turn:

- Excess readmissions penalties
- Value Based Purchasing reductions
- Negative Market Basket Adjustment
- Disproportionate Share payment reduction of 75%
- Coding and documentation adjustment reductions
- Hospital Acquired Conditions penalties

At the same time, CMS is promoting various payment bundling and at-risk reimbursement systems that both consume resources and add uncertainty to future payments.

Clearly, hospitals must identify and recover every dollar they earn in the current environment, and unfortunately the new regulations and requirements mean that fewer resources than ever are available for these efforts.
Financial Impact

Based on our analysis of recent Medicare discharge data, the annual financial impact of the Transfer Rule is approximately four billion dollars in reduced reimbursement across the system. In our experience, approximately 12 to 15 percent of Transfer DRG claims are underpaid. With an average payment reduction per claim of approximately $3,500, the impact to hospitals is significant.

Annual Financial Impact of the Medicare Transfer Rule on Hospitals

$4 Billion
Total annual reimbursement reduction across the system

12%-15%
Percentage of transfer claims that are underpaid

$3,500
Average payment reduction per claim

2014 BESLER Consulting
Why Do Underpayments Occur?

An important factor in the Transfer Rule and Medicare’s calculation of hospital reimbursement is the discharge status code.

The discharge status code is assigned by the hospital based on the expected treatment, if any, planned after the patient leaves the care of the hospital. The proper discharge status code is determined after consultation with the patient and the patient’s family, their physician and hospital personnel. It can indicate, among other scenarios, that a patient will be discharged to:

- Home
- A nursing home
- Home health care
- A rehabilitation facility
- A psychiatric facility, or
- Another acute care hospital

Only certain discharge status codes are impacted by the Transfer Rule.

Unfortunately, reality dictates that not everything that is planned after discharge actually occurs. In some of the cases impacted by the Transfer Rule, the care the patient receives after discharge from the original acute care hospital doesn’t correlate with the discharge status that was assigned, and the hospital may be underpaid as a result.

There are several significant causes of Transfer DRG underpayments.
When assigning the discharge status code to the patient's bill, the hospital does not always have enough information available to make the proper assignment. The discharge plan may lack the level of care specificity that is needed in order for the proper assignment to occur. In this situation, assumptions may be made based on the name of the post-discharge care provider.

Many post-acute providers furnish multiple disciplines of care. Without accurate documentation, the wrong discharge status code may be selected, leading to an underpayment. Sometimes, home health care is planned post-discharge, but the patient or family makes other arrangements or delays care.

For example, instead of home health care by a licensed home health agency, the patient's family may cancel the care plan and decide to take care of the patient at home themselves. The hospital is unaware that the plan of care has changed, is reimbursed at a lower level, and an underpayment has occurred.

Finally, some discharge status codes are used infrequently, and occasionally a hospital billing system is missing a particular code. In this case, the “next best” code will likely be assigned, and this code may inappropriately trigger the Transfer Rule when CMS determines the hospital’s reimbursement for that claim.
Why Doesn’t CMS Detect Underpayments?

From the inception of the Transfer Rule, CMS acknowledged that errors can occur with discharge status assignment. They also discussed their plans for edits by the Medicare contractors to identify “overpayment” situations after the receipt of claims from the hospital and post-acute providers. Audits by the Office of Inspector General (OIG) confirmed that hospitals were significantly overpaid and edits were finally implemented.

For example, if a hospital believes a patient is being discharged to home, but the patient’s treatment after discharge in fact includes home health or skilled nursing care, an overpayment may result. The Medicare contractor will identify this in the claims data and take back the entire original payment, not just the difference between the original payment and the Transfer DRG payment amount. The hospital will then need to submit a claim adjustment to reflect the corrected discharge status.

*CMS made it clear from the start that the development of edits would only apply to overpayments*; hospitals would have to perform their own validation of proper discharge status code assignment to detect underpayments.

In the past few years, CMS has developed the Recovery Audit Contractor (RAC) program to identify overpayments and underpayments for claims, including those impacted by the Transfer Rule. This is a controversial issue, as ironically the RACs identify underpayments through a computer algorithm and do not validate level of care with post-acute providers. Therefore the RACs are “recovering” Transfer DRG underpayments that are not in compliance with Medicare regulations.
Addressing the Issue

Even though the causes of Transfer DRG underpayments are fairly well understood, that doesn't mean the underpayments are easy to identify.

A good process requires sometimes tedious research, and a detailed understanding of the financial and clinical factors that drive Medicare Transfer DRG billing. Identifying claims impacted by the rule and using Medicare eligibility systems are essential steps; however, they are not the only steps required to confirm an account is an underpayment.

For example, many Medicare patients are transferred to a nursing home after a hospital stay. The appropriate discharge status code assignment depends upon whether the nursing home is certified by Medicare, the levels of care provided by the nursing home, the level of care actually received and required by the patient at the nursing home, whether the patient's permanent residence is at the nursing home and other factors.

In fact, it can be quite easy to adjust a Medicare bill in a non-compliant manner when attempting to recover Transfer DRG underpayments, resulting in the submission of a potential false claim. A less experienced researcher may assume from the presence or absence of certain information in Medicare eligibility and billing databases that a Transfer DRG underpayment exists, when in fact it does not.
In certain situations, some post-acute care providers don’t submit timely bills to Medicare. This means that follow up with post acute care providers and Medicare contractors is required to confirm that all relevant information is available when making a final determination of an underpayment.

The follow up work can truly be significant if it’s done correctly. After the proper data analysis to identify potential underpayments, which can involve re-pricing the claims as non-transfers, eligibility and billing information in CMS databases must be reviewed. This is followed by phone calls to Medicare contractors, nursing homes, home health agencies, etc. Finally, claims must be adjusted and a proper audit trail maintained for all activity.
Provider Options for Recovering Underpayments

There are basically three approaches to addressing the issue: an internal process, a consultant/vendor or reliance on the RAC. Each approach has pros and cons, as seen in the chart below, and some providers may use one, two or all of these approaches to identify their Transfer DRG underpayments.

<table>
<thead>
<tr>
<th>Option</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-house</td>
<td>• lower pure cost</td>
<td>• lack of required expertise</td>
</tr>
<tr>
<td></td>
<td>• higher level of control</td>
<td>• absence of adequate resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• significant competing priorities</td>
</tr>
<tr>
<td>Vendor</td>
<td>• low financial risk (normally contingency-based)</td>
<td>• higher pure cost</td>
</tr>
<tr>
<td></td>
<td>• generally higher recoveries</td>
<td>• lower level of process control</td>
</tr>
<tr>
<td></td>
<td>• greater Transfer DRG expertise</td>
<td>• need for vendor management</td>
</tr>
<tr>
<td></td>
<td>• lower hospital resource requirements</td>
<td></td>
</tr>
<tr>
<td>RAC</td>
<td>• no hospital resource requirements</td>
<td>• automated identification with no validation results in false positives and submission of potential false claims</td>
</tr>
<tr>
<td></td>
<td>• rate is lower than an external vendor</td>
<td>• RAC appeal required to contest invalid underpayments</td>
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<tr>
<td></td>
<td></td>
<td>• not all underpayments are identified</td>
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In-house

Some organizations such as larger health systems have dedicated resources assigned to special projects that include the identification of Transfer DRG underpayments and following up to make a proper final determination. Handling the work internally may allow a hospital or health system to reduce expenses and maintain full control of the process.
However, it’s not a simple calculation to determine if a claim has been financially impacted by the Transfer Rule, and there can be a lot of wasted follow up work unless it’s properly focused on the real opportunities. It can be like looking for a needle in a haystack. The staff required to perform the follow up work often have other critical billing responsibilities. As we’ve already seen, there is a significant potential compliance risk if all of the information is not reviewed and applied correctly.

**Vendor**

Many providers outsource the recovery effort to an external partner and pay a contingency fee for the recoveries collected. While this option carries more pure cost than an in-house solution, recoveries tend to be higher.

Often, providers will supplement their in-house recovery efforts with a vendor who will ‘go behind’ them to search for and research more complex potential underpayments. Many providers stop here, assuming that at this point they have optimized their recovery efforts. Still, significant revenue can be left on the table as not all vendors are experienced with the unique intricacies of recovering Transfer DRG underpayments.

**RAC**

Finally, some providers, in an effort to keep things simple, rely upon the RAC to identify and recover their underpayments. The cost is far less than a vendor and the provider has limited responsibility. Unfortunately there is significant compliance risk associated with this option and many providers are unaware of the risks involved.
Optimizing Third Party Recovery Efforts

Revenue recovery at hospitals is a major issue. Financial managers who are tasked with recovering lost revenue have an important responsibility. Many institutions have gone to great lengths to ensure that their in-house capabilities are optimized to capture lost Transfer DRG revenue and even supplement their efforts with third party vendor review. However, as mentioned earlier in this paper, the follow up process is often tedious and the nuances of recovering revenue in a compliant manner can escape even the most seasoned financial managers.

It can be difficult to grasp that despite efficient in-house systems and an outside vendor review that revenue could still be unaccounted for. This is often a source of consternation for financial managers who are accountable for being thorough, but still harbor doubts about whether they could recover more. Data from transfer audits conducted by Besler Consulting have shown that **30% more revenue can often be recovered on top of revenue recovered from in-house reviews and audits by other vendors combined.** This indicates that financial managers have the opportunity to champion additional efforts to recover transfer revenue that may otherwise be lost.

It is important to note that claims that have gone beyond the one year timely filing limit can still be reviewed. Retrospective reviews can be conducted on four years of previous claims.

To optimize third party recovery efforts, consider the following questions when evaluating external vendors:

- Has the vendor performed recovery work since 2007 when the transfer rule expanded?
- Has the service received HFMA Peer Reviewed designation?
- Is the vendor focused on ensuring that the recovery process is compliant?
- Is a review by clinical staff provided?
- Does the vendor review every discharge impacted by the transfer rule?
- Does the vendor confirm that prior recovery efforts yielded all eligible underpayments?
- Is the vendor experienced with Medicare Administrative Contractors?
- Does the vendor have the ability to process claims outside of timely filing?
- Can the vendor perform claim adjustments and track claims through adjudication?
- Does the vendor deliver full audit documentation and support?
- Does the vendor offer a software option to supplement in-house recovery efforts?
- Does the vendor include Medicare Advantage review?
Conclusion

The average hospital loses up to hundreds of thousands of dollars in reimbursement due to Transfer DRG underpayments annually. In the current healthcare reform environment, it’s critical that hospitals capture every dollar of revenue to which they are entitled.

Transfer DRG underpayments typically occur through no fault of the hospital, and the identification of underpayments is not straightforward. It is imperative that hospitals take the necessary steps to recover revenue they are due through the implementation of in-house processes supplemented by qualified assistance from expert third parties.
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