

The Flip Side

How hospitals and IDNs can regain some revenue portions lost from Transfer-DRGs.

When the Centers for Medicare and Medicaid Services (CMS) tightens its belt, hospitals and IDNs around the country feel the pressure. In recent years, CMS determined that they were paying a full reimbursement to both an acute care provider and a post acute care provider for services related to the same DRG. To correct this problem, CMS developed “Transfer-DRGs” and the post acute care payment rule. A DRG is designated a Transfer-DRG whenever certain criteria are met involving continuation of care in a post acute setting after discharge from an acute care provider. Payment to the acute care provider is reduced whenever the acute care length of stay is more than one day less than the geometric length of stay for that DRG. In 2004, CMS developed edits that check all acute care claims with a discharge status of 01 (discharged home) to see if the inpatient acute care claim had a properly coded discharge status. If the acute care provider had coded a 01 and a post acute care provider had filed a claim with matching dates of service, CMS would take back the original payment to the hospital and give a reduced payment.

However, no similar checks and balances were established to correct underpayments to acute care providers. CMS puts that responsibility on the providers.

Underpayments do occur, however, and it’s essentially a drain of revenue if providers don’t have the resources in place to find the discrepancies. Houston, Texas-based MCare Solutions, Inc., provides Transfer-DRG reimbursement recovery services to the healthcare industry. MCare Solutions analyzes and finds claims that have a potential for additional reimbursement without any on-site resources and typically without medical records being involved. *Hospital COO* talked with MCare Solutions President David Jupp about how Transfer-DRGs are affecting hospital revenue, and how hospitals can get some of that back.

HCOO: Why are Transfer-DRGs costing hospitals?

David Jupp: [They are costing hospitals] in two ways. First, Medicare is taking back reimbursements associated with some Transfer-DRGs. Secondly, providers are not realizing all the reimbursements that they’re entitled to, based upon what actually happens after a patient is discharged from their facility.

To elaborate on the first situation, CMS and the associated Medicare fiscal intermediaries (FIs) began in 2004 editing all claims that have a 01 discharge status code, meaning that a patient was discharged home from an acute care provider. Upon the subsequent receipt of that same patient’s claim from a post-acute care provider, such as a skilled nursing facility or home health agency, the FI will go back to see whether or not they had a prior claim from an acute-care facility for those same dates of service. If they get a match,

they’ll review that acute care facility’s claim, determine if they billed the 01 code, and if that claim then is subject to a reduced payment because of the transfer payment rules. If so, Medicare takes back the money they originally paid the hospital and makes a reduced payment.

In regard to the second issue, there are a number of discharge status codes other than 01 that might have a coding “error,” or “variance,” if you will, based upon the post-acute care claim activity and what actually happened after a patient discharged.

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This part of the problem typically affects 1 to 3 percent of a hospital’s acute care Medicare inpatient discharges. On average, each one of those status code “errors” is worth approximately \$2,000 to the hospital — provided you can find it, and then file a corrected claim. So, if a hospital has 5,000 Medicare discharges a year, and 1 to 3 percent of those are incorrect, that’s somewhere between \$100,000 and \$300,000 that a hospital with this level of errors can recover for each year of a retrospective review. We typically review at least four years of past discharges, so the potential recoveries can easily grow three-fold to four-fold, or between \$300,000 to \$1.2 million for that size facility.

HCOO: Are hospitals aware of this issue?

Jupp: Hospitals are certainly aware of “takebacks.” As for retrospective recoveries, we’ve done a lot of educating over the last couple of years since we’ve been doing this. We started in October 2005, when hospitals really began to take notice of the issue and how much money that they had to pay back to CMS each year. We’ve succeeded in educating over 200 hospitals in the last couple of years that there is a flip side to the issue and that the flip side can operate in their favor.

HCOO: Are there certain kinds of hospitals/IDNs that need to be more aware of Transfer-DRGs?

Jupp: The ones that are affected most are the acute care hospitals. They bare the brunt of it. In addition, inpatient rehabilitation facilities are also affected, but to a lesser extent.

HCOO: Do you see an increase coming in the number of Transfer DRGs?

Jupp: The program began in the federal fiscal year of 1999 with 10 DRGs designated as “Transfer-DRGs.” In October 2003, CMS increased that number to 29. In October 2005, they increased it to 182. That, as you might expect, was when it really began to be noticed. In October 2007, under the new MS-DRG system, the number of Transfer-DRGs increased to 273. Within the federal regulations, there is a formula that is applied to all discharges to see which DRGs are meeting the criteria established by this formula for categorization as a Transfer-DRG. The formula is based upon volumes and a variety of other factors. So, as the Medicare population increases, there’s no reason to think that the number of Transfer-DRGs will not at least remain constant, if not proportionately increase.

HCOO: What are challenges that a hospital faces in trying to detect a loss because of Transfer-DRGs?

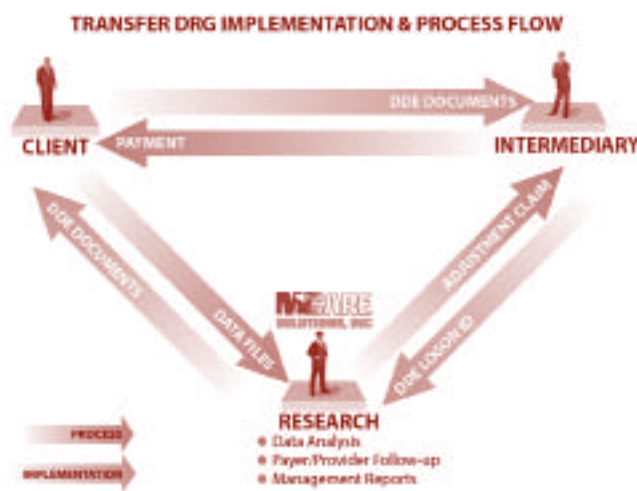
Jupp: First, this is a very difficult issue to deal with at the time of discharge. Basically, in order to identify these types of discharges, the hospital would have to have a crystal ball that would tell them whether a post-acute care provider will be able to submit a part A claim or whether the patient will do as the physician ordered. In other words, you can best identify problems retrospectively.

Another factor, particularly in regard to home health and post acute care, is the hospital has to get the patient to be as compliant as possible with the physician’s orders. For example, if the patient decides not to go to home health, or does not enter home health within the required three days of discharge from the acute care side, the hospital’s reimbursement can be negatively affected. So, follow-up by hospital personnel with patients and post-acute care providers after discharge is another challenge.

HCOO: Is outsourcing these kinds of services a trend we’ll see more of with hospitals?

Jupp: Probably so, given the nature of the problem, the increasing awareness among hospitals for potential recoveries, and the limited resources hospitals typically have just to manage their day to day business.

For example, the most effective way to ensure that status codes are correct is to review them on a retrospective basis. However, the review period shouldn’t be any sooner than nine months from discharge, because the post acute care provider has as much time to get a claim in as the acute care



provider does. By looking at claims at least nine months old, you’re giving the post acute care facility an opportunity to file their claim. Otherwise, you might be duplicating claims. You have to look at it retrospectively, while allowing enough elapsed time from discharge. So, you have to find the resources to do that. Given that hospitals are typically strapped for resources to manage their current operations, it’s typically easier to use outside resources. Further, these outside resources often specialize in this area, as our company does, thereby maximizing the potential recoveries.

The next part is, how much volume is involved? If you’re a hospital that has 10,000 annual Medicare discharges, then you’ll have to look at every one of those to determine the 100 to 300 that meet the criteria for successful reimbursement recovery. Multiply that volume by several past years of review, and you can easily see the manpower problem. It’s not that providers can’t do the reviews with their own staff, it’s just a resource and timing issue, along with perhaps lack of technology to assist in the process of evaluation. We’re fortunate to have a proprietary system that filters the probable recoveries out for our staff automatically, so we’re a bit more efficient in the process. **HCOO**