SEE YOUR REV CYCLE DIFFERENTLY

# TRANSFER DRG RESOURCE GUIDE

## Your hospital's journey to recovering Transfer DRG underpayments

- Develop a better understanding of Medicare transfer DRGs
- Gain insight on how to identify and recover transfer DRG underpayments while also minimizing costs and challenges for your hospital
- Learn about recovery services and the right questions to ask when choosing a Transfer DRG vendor
- Discover the solution: An end-to-end, fully automated process

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With multiple locations and thousands of Medicare patients discharged to a post-acute care facility annually, it's incumbent upon health systems and hospitals to identify claims that failed to transfer under Medicare's Post-Acute Care Transfer rules.

These claims are subject to reduced payments if patients are discharged as a transfer but don't receive the planned post-transfer acute care. This scenario puts hospitals at risk for underpayments – payments that rightfully belong to hospitals. While most hospitals work to recover transfer DRG underpayments, they likely aren't capturing 100% of underpayments, resulting in significant dollars going unrecovered.

## Understanding Medicare Transfer DRGs

Centers for Medicare and Medicaid Services (CMS) pays for Medicare inpatient hospital care based on Diagnosis Related Groups (DRGs). Transfer DRGs are paid under the Post-Acute Care Transfer (PACT) rule. CMS adopted the PACT rule in the 1990s after realizing that some brief hospital stays were being transferred to another healthcare provider to complete treatment and recovery but were still being reimbursed at the full DRG rate. Medicare was, in effect, paying twice for certain patients' treatment. In some instances, CMS paid the hospital the full DRG rate, regardless of the patient's length of stay (LOS), and also paid the post-acute provider the full case rate. For these cases, CMS concluded that the hospital should receive a per diem payment instead of the full DRG rate to account for the short stay. Since its inception more than 20 years ago, the rule has grown from 10 DRGs to 280 DRGs, which has put a portion of a hospital's Medicare payments at risk.

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# Identifying Transfer DRG underpayments is costly + challenging

Certain DRGs under Medicare's PACT rules are subject to reduced payments if patients are discharged as a transfer but don't receive the planned post-transfer acute care.

This means your hospital is at risk for underpayments. Nearly half of all Medicare discharges are coded as transfer DRGs. Underpayments can add up quickly and cost hospitals significant amounts of revenue that Medicare rightfully owes.


## A hospital generally has three options to identify and recover transfer DRG underpayments:

- **An internal team dedicated to manually identifying transfer DRG underpayments** and following up with a proper final determination. Oftentimes internal staff lack the time and/or experience for an in-depth review of the transfer DRG claims impacted by the Transfer Rule. This often leads to missed opportunities or tedious follow-up efforts.

- **An outsourced solutions partner who manages the recovery effort for a fee.** This option typically results in greater revenue recovery because reviewers that specialize in transfer DRG recovery have more knowledge and familiarity with the process.

- **A secondary or tertiary service to validate current process(es).** This ensures hospitals are maximizing recoveries, giving them peace of mind that valuable revenue isn't slipping through the cracks.

# Transfer DRG recovery

## What are the options?

While it's not usually affordable for most hospitals to staff an internal team dedicated to manually finding transfer DRG underpayments, many hospitals do outsource this process to a recovery vendor partner. While these vendor partners are trying to get to the same outcome of identifying transfer DRG claims, they have many things in common, but some distinct features that set them apart. Most vendors employ technology and algorithms to find transfer DRG claims and use a contingency-based pricing model (i.e. they charge a percentage of the overall total recovery). What is different among these vendors is their ability to directly connect to Medicare's system and the Common Working File (CWF), considered by Medicare to be the source of truth for claim data. Rather than relying on the data in Medicare, most transfer DRG vendors must rely on the patient's medical records. Medicare does not consider a patient's medical records as the true source of discharge information. Medicare relies on the Common Working File to identify patients who failed to transfer, rather than patient medical records. According to CMS (Pub. 100-04 Medicare Claims Processing Manual, Transmittal 140, Change Request 3240), hospitals will not be out of compliance for changing a patient's status codes due to Common Working File edit 7272, even if the patient's medical record doesn't support the change. In most cases, vendor partners also require a significant amount of upfront work from hospitals. Specifically, hospitals must manually extract and send their Medicare claim data monthly or quarterly to the vendor for review. This process can take ongoing IT resources and is also prone to error; if queries of data are not done correctly, claims can slip through the cracks. Since transfer DRG recovery vendors each use different processes and technology, it makes financial sense for a hospital to use multiple vendors for a primary, secondary and, in some cases, a tertiary review. This ensures a hospital has covered all its bases to recover as many underpayments as possible.

## Questions every hospital should consider when choosing a Transfer DRG recovery vendor:

- Must your team generate and send all your Medicare claim data on its own?
- Do you have to locate and provide all your patients' medical records?
- Does the vendor have direct access to your transfer DRG claims through Medicare?
- Does the vendor focus only on recovering high-dollar claims?
- Once the vendor identifies claims that failed to transfer, will it rely on the hospital's team to manually update those claims?
- How quickly can the vendor identify claims and how quickly can the hospital recover payment?
- What is the vendor's payment model?
- How much, on average, has the vendor recovered per claim?

**Your chosen vendor's technology will largely determine the number of eligible claims discovered and paid.**

# Audits + overpayments

## In a November 2019 report, the Office of Inspector General (OIG) found that Medicare improperly paid acute-care hospitals $54.4 million for 18,647 inpatient claims subject to PACT.

The hospitals improperly billed the claims by using incorrect patient discharge status codes, according to the report. Most of the claims were coded as discharges to home rather than as transfers to post-acute care. When CMS performs an audit, it's important to note that it's primarily looking for cases where hospitals have discharged a patient to home as a non-transfer. However, if the patient receives post- acute care, such as home health services, he or she should have a transfer discharge status. A discharge to home health services is not always a discharge to home. These cases could result in overpayments to the hospital where CMS paid a full amount when it should have paid a partial or per diem payment because the patient was transferred to post-acute care. In an audit, CMS takes back the amount that was overpaid, leaving hospitals with the reduced per diem payment.

## How do Transfer DRG recovery services fit in?

Transfer DRG underpayment recovery vendors look for the exact opposite set of claims than those OIG was focused on finding. Transfer DRG recovery vendors examine cases in which the patient was discharged to post-acute care, but instead failed to receive that care. In its November study, the OIG specifically excluded claims where the discharge status codes indicated the patient received post-acute care.

**According to the OIG report, it excluded inpatient claims:**

- With discharge status codes indicating discharges to home with home health services and discharges to SNFs and non-IPPS facilities because these claims are paid at the per diem rates
- In which beneficiaries were discharged to home to resume home health services
- That were billed by acute-care hospitals in Maryland and by cancer hospitals because these hospitals are not paid under the IPPS
- In which beneficiaries began hospice care after being discharged from the acute-care hospitals
- Where beneficiaries left the hospital against medical advice but began receiving post-acute care services after leaving.

*The OIG audit only focused on overpayments, and hospitals will not receive any adjustments for underpayments based on the audit.*

## Can Transfer DRG recovery services put you at risk for takebacks?

The risk of takebacks is low, but not nonexistent, with transfer DRG recovery services. A hospital's risk is often based upon its internal practices and/or the accuracy of its contracted vendor. Because transfer DRG recovery services change discharge status in many cases to home, those claims that were previously adjusted by transfer DRG recovery services are included in the audit. During the adjustment process, CMS takes its own second look at these claims and evaluates whether there is just cause for payment. Just because a claim is reopened and an adjustment attempted doesn't mean that CMS will automatically pay. If CMS agrees with the new assessment and pays the claim, the hospital can then expect the CMS data aligns correctly at that point in time.

## Minimizing audit risk

Transfer DRG recovery services should primarily focus on claims six months or older. This ensures post-acute claims have a chance to appear in the CWF with accurate patient data. If hospitals adjust inpatient claims too soon after discharge, there is a risk that the post-acute care information will be missed because the claim has not yet been billed to Medicare.

The safest way to mitigate risk is by using a vendor with Medicare expertise, such as being an approved Medicare Network Service Vendor with access to the CWF. CMS uses the CWF to perform audits and defaults to its data over internal medical records.

It's recommended hospitals check the vendor's historical adjustment success rate across its entire client base. Make sure it has a high success rate of claims submitted for adjustments that CMS agreed with and paid.

What percentage of a recovery service vendor's adjusted claims does CMS pay? Low rates indicate a disagreement in the data used by a vendor and CMS, thus exposing a hospital to additional audits.

## Waystar: A trusted Transfer DRG recovery partner

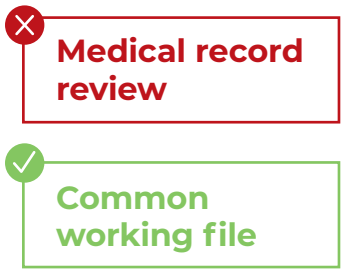
No RCM vendor knows Medicare and transfer DRG recovery better than Waystar. When it comes to revenue integrity, Waystar can find dollars a hospital may have missed. With our Transfer DRG tool, our proprietary intelligent technology employs an automated end-to-end process to identify transfer DRG underpayments and then adjusts those claims on a hospital's behalf in Medicare's system.

Other transfer DRG recovery services require busy hospital teams to retrieve and send Medicare data, but Waystar has direct access to Medicare data. This eliminates the time and manual work associated with extracting and sending a data file. For more than 20 years, Waystar has been a trusted advisor to CMS, and our system and data access is superior to any other solution in the market.

Waystar' Transfer DRG is proprietary software designed to conduct underpayment reviews on a hospital's behalf and ensure reimbursement for those claims. Our end-to-end, automated process captures the full DRG reimbursement and then adjusts the claim in the CWF/DDE.

## The average recovery for our clients is $3,500 per underpaid claim.

We have performed reviews after similar services and we always find additional underpayments regardless of whether it's a first-time, secondary or even tertiary review. We discover more underpayments faster thanks to the combination of our intelligent technology and direct access to Medicare. Medicare relies on the CWF to identify patients who failed to transfer, rather than patient medical records.




As of January 1, 2020, Medicare stopped accepting claim submissions that include a beneficiary's HICN. To address this issue, Waystar offers conversion of HICNs to the new MBIs. Using our MBI Lookup tool in tandem with Transfer DRG has resulted in a 20% increase in recoveries for hospital clients.

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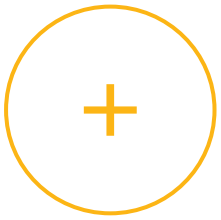
# What makes us different?

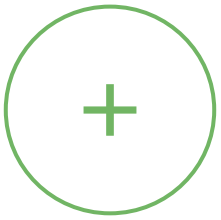
+ Deep understanding of the Medicare system, rules and regulations.
+ We're a CMS-approved Medicare NSV.
+ We rely on Medicare's Common Working File, not internal medical records. Our solution integrates with the state FI/MAC to perform DDE/EDI transactions in the CWF. This allows us to do 98% of the work and review 100% of a hospital's Medicare inpatient discharges. For more information, visit the CMS Medicare Claims Processing Manual, Pub. 100-04, Transmittal 140, Change Request 3240.
+ Comprehensive condition code and discharge status code review.
+ A 100% review, capturing both high-dollar and low-dollar accounts.
+ Fully automated process, reviewing all 280+ Diagnosis-Related
+ Groups subject to the Post-Acute Care Transfer (PACT) rules.
+ Ability to easily convert patient HICNs to MBIs, which are now required by Medicare for claim submission and other transactions. This has resulted in a 20% increase in recoveries for hospital clients.
+ Eliminate manual processes and human error.
+ Retrospective four-year review from present day.
+ Perfected a true end-to-end process.
+ Due diligence guarantee.
+ Little effort needed from your hospital's staff team.
+ We identify underpayments on average in 5 business days. Once we adjust your impacted claims, you should receive Medicare payment within 2-4 weeks.

# EXPLORE OUR ALL-IN-ONE PLATFORM



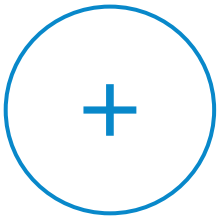
## Financial Clearance

Verify insurance coverage to reduce claim rejections and denials



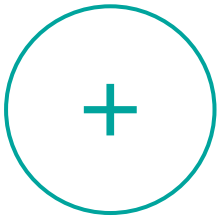
## Revenue Capture

Find missing charges and capture revenue you're due



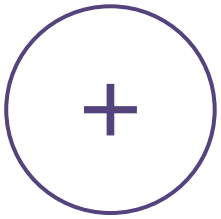
## Claim Management

Automatically submit and track claims, and reduce AR days with intelligence-driven workflows



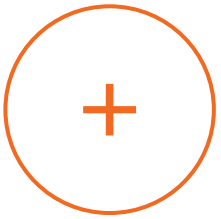
## Payment Management

Prevent denials and automate appeals



## Denial Prevention + Recovery

Collect patient payments, determine propensity to pay and improve the patient experience



## Analytics + Reporting

Get insights into outsourced agency effectiveness

**Get in touch today at**
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### ABOUT WAYSTAR

*Waystar provides next-generation, cloud-based technology that simplifies and unifies healthcare payments. Our platform removes friction in payment processes, streamlines workflows and improves financials for providers in every care setting.*