Medicare Transfer DRGs: Capturing Maximum Reimbursement

Glenda McCoy
Manager, Care Coordination
&
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Manager, Coding and Data Management

University of Missouri Health Care
Learning Objectives

• Understand how Medicare-based reductions in payment for inpatient visits with specific DRGs may be impacting your bottom line

• Demonstrate how one organization was able to effectively audit discharges over two six-month spans to identify visits with a disposition to home health but for which those services were not fulfilled or initiated within three days per Medicare requirements

• Gain a firsthand look at how staff education initiatives and home health facility collaboration could secure $250,000+ in reimbursement otherwise left on the table
Glenda McCoy, MSW, LCSW, ACM
Manager of Care Coordination
University of Missouri Health Care

In her role, Glenda works with RN and SW Case Managers, Social Workers, and Care Transitions Resource staff in collaboration with Utilization Management RNs to ensure the progression of patients through the inpatient stay toward a safe and effective discharge transition. Glenda joined MU Health Care in 2004.

Glenda has enjoyed being part of transforming the department to a new case management model. RN and SW staff were offered opportunities to become case managers and have received much training in Medicare regulations, progression of patient care, and discharge transition best practices. While it has been challenging, it has also been greatly rewarding to see the development of the case managers, the utilization management analysts, the resource staff team, discharge call nurses, and the social workers who work together to ensure successful patient transitions to home or post-acute care.
Today’s Speakers:

Terri Benskin, MHA, RHIA, CCS
Manager of Coding and Data Management
University of Missouri Health Care

Terri received her Master of Health Administration from University of Missouri and is a Registered Health Information Administrator (RHIA) and Certified Coding Specialist (CCS). Terri is currently pursuing her PhD in Health Informatics with the University of Missouri.

Terri has been with MUHC since 2004 and has the opportunity to work with the Toxicology and Drug Monitoring Lab, Rural Health Programs, and Telemedicine. However, she has spent the majority of her MUHC career with the Health Information Services. In her current role, she is responsible for facility coding and edits, clinical documentation improvement, emergency department and ambulance billing, and the recovery audit program. Terri also serves as a liaison with the Office of Clinical Effectiveness to ensure concordance between coded data, documentation, and actual reportable serious patient safety events.
Today’s Speakers:

Jessica Mayfield
Manager of Revenue Management
University of Missouri Health Care

Jessica’s background has been in dialysis, patient accounts, managed care/contracting, finance, ENT, and chargemaster. She has been in the non-profit and for-profit healthcare field for 21 years.

Jessica has been with the University of Missouri since 2009 and has had the opportunity to work in many roles within the system. Her current role is leading the chargemaster team, which is responsible for the hospital and outpatient clinics’ chargemaster, annual pricing increases, and billing compliance. She oversees the VAT (value analysis team) for financial impact and regulatory billing guidelines/compliance and manages the nurse auditors who are responsible for: audits of the medical records, on-site payer audits, and charge capture audits.
University of Missouri Health Care at a Glance

2017 in NUMBERS

643,452 clinic visits (all sites)
216,345 total patients
212,127 Missourians
4,218 out-of-state
562 patients transported by helicopter

26,995 patient discharges

25,643 major surgical operations

78,297 E.R. + trauma visits

306,793 radiological exams + treatments
1,541,337 lab tests
7,090,180 pharmacy orders

5 HOSPITALS
- Ellis Fischel Cancer Center
- Missouri Orthopaedic Institute
- Missouri Psychiatric Center
- University Hospital
- Women’s and Children’s Hospital

2,338 BIRTHS

5,945 total staff
- 697 medical staff
- 5,248 other staff

595 beds
- 147 intensive care
- 448 acute care

*Based on fiscal year 2017 (July 1, 2016-June 30, 2017)
University of Missouri Health Care at a Glance (Cont.)

The Culture of Yes
Together we: Care, Deliver, Innovate and Serve

VALUES
- CARE
- DELIVER
- INNOVATE
- SERVE

BEHAVIORS
- The difference between Pros and Amateurs
- 10/5 Rule
- Say Do Ratio 1:1
- Everything you need, but nothing more
- No Public Venting
- Warm Welcome
- Anticipate Needs
- Fond Farewell
- Big Impact and Small Wake
- Innovation finds a way
- "Is there anything I can do for you? I have the time."
Revenue Cycle

Where CLINICAL meets FINANCIAL
Care Coordination

• Case Management

• Utilization Management

• Post-Acute Referral Center

• Team of RNs, SWs, and transition staff

“Advocating for the clinical and financial health of our patients.”
Care Coordination – Why We Needed a Change in Model

- Nursing shortage
- 10,000 new Medicare-eligible patients daily in the U.S.
- Heightened regulatory environment with Medicare patients
- Increased focus on reducing readmissions, and avoidable stays
- Utilization of resources (management) required by payers
- Transitions of care managed to provide best outcomes
- New payment models (bundles, etc.)
- Discharge Planning CoP’s will require ALL patients to be screened within 24 hours
- Extensive data analysis on annualized patient volume/service patient days and discharges completed on FY16
Care Coordination (Cont.)

Identification & Prioritization

Plan for the DAY

Right Care

• Facilitate interdisciplinary communication

Right Level

• Advocate & Educate

Right Time

• Coordinate progression of care

Plan for the STAY

Plan for the WAY

Outcome Measures

• Facilitate key transitions

• Optimize resources

• Bridge care continuum

• Reduce avoidable stays

• Reduce Readmissions

• FTE Neutral

• CoP compliance

• Staff/patient engagement

Handoff is KEY!

Pre-Admission
ED
Acute Care
Ambulatory Care
Post-Acute Care

Utilization Management

Case Management

Social Work

Care Transition Resource Specialists

Predetermined Patient Criteria

• Review EMR
• Assign Patient Care Coordinator
• Initiate utilization management
• Engage patient and caregiver
• Prepare coordination plan
Coding and Data Management

Coding
- Inpatient
- Outpatient
- Emergency Department

Clinical Documentation Specialists
- Inpatient
- Emergency Department

Bill Holds & Denials

Emergency Department Charge Entry

2018 Spring Member Retreat
Revenue Management

• Responsibilities of this department include:

**Chargemaster:**
Maintain all billable hospital/clinic charges and optimize reimbursement

**Pricing Review:**
Annually done for hospital and clinic – 4/1

**Value Analysis:**
This team reviews reimbursement and billing compliance issues with **new** products/services

**Nurse Audit:**
Ensure charges are supported by medical record; audit and coordinate payer on-site audits; charge capture audit

**Compliance & Regulatory:**
Variety of tasks related to external audit processes such as CMS, Missouri Medicaid, OIG, other government and third-party payers, etc.
Transfer DRGs and Post-Acute Care Transfer Policy
What Is a DRG?

• CMS reimburses for inpatient hospital care through the Diagnosis-Related Group (DRG) methodology

• A DRG system divides diagnoses into more than 20 major body systems and subdivides them into almost 500 groups

• Beginning in 2007, CMS transitioned to a severity-adjusted DRG that takes into consideration the presence of major complications and/or comorbidities
  – This system is known as Medicare Severity-Diagnosis Related Groups (MS-DRGs)

• Various factors determine DRG payment, including the hospital resources necessary to treat the condition
What Is a **Transfer** DRG?

Medicare determined that when certain patients were **transferred** from an acute care hospital to another provider...

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Mid-1990s

...the transferring facility was receiving **full** payment for only providing a portion of the necessary care

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1997

The **Post-Acute Transfer (PACT)** policy was established to prevent Medicare from paying for the **same care twice**

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Policy Manual

2018 Spring Member Retreat
Number of DRGs by Year:

- 1999: 10 DRGs
- 2005: 30 DRGs
- 2007: 190 DRGs
- 2011: 273 DRGs
- 2014: 275 DRGs
- 2016: 279 DRGs
- 2018: 280 DRGs
Reduction in DRG Payment

• The patient’s LOS is at least **one day less** than the geometric mean LOS for the DRG

• The patient is transferred to a:
  – Long-Term Care Hospital
  – Rehabilitation Facility
  – Psychiatric Facility
  – Skilled Nursing Facility
  – Home Health Care
  – Cancer Hospital
  – Children’s Hospital
PACT Example #1

- Hospital-specific per diem is calculated for each DRG based on GMLOS:

\[
\text{DRG Payment} = \frac{\text{Per diem rate}}{\text{GMLOS}} \times (\text{LOS} + 1)
\]

**Day 1**
- Double the per diem rate

**Subsequent Days**
- Per diem rate

**Total Payment**
- Not to exceed full DRG Payment
PACT Example #1 (Cont.)

\[
\text{DRG Payment} = \frac{\text{GMLOS}}{x} \times (\text{LOS} + 1)
\]

\[
\frac{12,000}{4.2} \times (2 + 1)
\]

Final Payment = $8,571.43

DRG 100: Seizure w/ MCC
GMLOS: 4.2
Hospital Payment: $12,000

Actual LOS: 2.0
Discharge Disposition: SNF
PACT Example #2

- “Special Pay” PACT MS-DRGs are those with exceptionally high costs on the first day (usually associated with high device costs)

**Day 1**

50% of the full DRG payment plus the per diem amount for the first day

**Subsequent Days**

50% of the per diem rate for each remaining day

**Total Payment**

Not to exceed full DRG Payment
PACT Example #2 – Special Pay Scenario

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>GMLOS</th>
<th>Discharge Disposition</th>
<th>Per Diem Rate</th>
<th>DRG Example Payment</th>
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<tbody>
<tr>
<td>266</td>
<td>7.0</td>
<td>SNF</td>
<td>$8,090</td>
<td>$56,630</td>
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</table>

<table>
<thead>
<tr>
<th>LOS</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Payment</th>
<th>Payment Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Days</td>
<td>$36,404</td>
<td>$4,045</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$40,449</td>
<td>($16,180)</td>
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<tr>
<td>3 Days</td>
<td>$36,404</td>
<td>$4,045</td>
<td>$4,045</td>
<td></td>
<td></td>
<td></td>
<td>$44,494</td>
<td>($12,135)</td>
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<tr>
<td>4 Days</td>
<td>$36,404</td>
<td>$4,045</td>
<td>$4,045</td>
<td>$4,045</td>
<td></td>
<td></td>
<td>$48,539</td>
<td>($8,090)</td>
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<tr>
<td>5 Days</td>
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<td>$4,045</td>
<td>$4,045</td>
<td>$4,045</td>
<td>$4,045</td>
<td></td>
<td>$52,584</td>
<td>($4,045)</td>
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<td>$4,045</td>
<td>$4,045</td>
<td>$4,045</td>
<td>$4,045</td>
<td>$4,045</td>
<td>$56,629</td>
<td>-</td>
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</table>
Overpayments

The OIG began conducting audits on **discharge status** and found a large number of errors.

Edits were established by CMS to concurrently identify **overpayments**.

If an overpayment is detected—the entire hospital payment is recouped."

"The hospital must resubmit the claim with the corrected discharge status, even when documentation indicates otherwise."
“52 percent of the time, hospitals may not be receiving the full reimbursement when beneficiaries are transferring to facilities or home health.”

Compass, Directional Training for Case Managers, 2017
Transfer DRG PDSA
Problem Statement

From June 2012 to December 2015

• Inpatient Encounters: 49
• Reimbursement Not Captured: ($148,824)

From January 2016 to June 2016

• Inpatient Encounters: 31
• Reimbursement Not Captured: ($99,983)
This project aims to increase revenue by ensuring the **correct discharge disposition assignment**. The target population is **100% of Medicare patients**, including specific managed Medicare inpatients, with a **home and home health** discharge disposition.
This project supports overall organizational goals by aligning with the following:

**Finance:**
Capturing the full DRG reimbursement and minimizing rebilling efforts

**Quality:**
Billing the correct discharge disposition
Assessing the Issue

- Exploration of **80 visits** with discharge disposition meeting AIM statement criteria to determine root cause

- **61%** had either refused home health services or were admitted to home health more than **3 days from discharge**

![Reasons Home Health Services Were Not Received](chart.png)
Interventions

• Provide Staff Education
  – Importance of discharge disposition to reimbursement
  – *Transfer DRG criteria requiring patients to be admitted to home health within 3 days or discharge*

• Implement new process for all Medicare inpatient encounters with discharge disposition of home health:
  – *Contact home health agency 4 days after patient’s discharge* to validate if home health services have been initiated
  – *If agency services were not initiated, the discharge disposition was revised to home/self-care in order to capture full DRG payment*
Home Health Agencies Contact by Month

- **January**: Phone Calls Made: 3, Changes to Discharge Disposition: 2
- **February**: Phone Calls Made: 5, Changes to Discharge Disposition: 2
- **March**: Phone Calls Made: 7, Changes to Discharge Disposition: 2
Results

• Increased **accuracy** of home health discharge disposition:

  Baseline:  
  95.70%

  Post-Intervention:  
  100%

• Decreased **revenue leakage** from incorrect discharge disposition:

  Baseline:  
  ($99,930)

  Post-Intervention:  
  $__________
Current and Next Steps

• Broaden the scope of the initial project:

Expand to review skilled nursing facility discharges

Implement concurrent coding to assist care coordination with appropriate discharge planning timelines and options

Educate medical team, coding staff, and case managers regarding best practices associated with transfer DRGs
# Reimbursement Recovery

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Recovery Amount Identified</th>
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<tbody>
<tr>
<td>June 1, 2012 – June 30, 2012</td>
<td>$11,502</td>
</tr>
<tr>
<td>July 1, 2012 – June 30, 2013</td>
<td>$314,785</td>
</tr>
<tr>
<td>July 1, 2013 – June 30, 2014</td>
<td>$399,492</td>
</tr>
<tr>
<td>July 1, 2014 – June 30, 2015</td>
<td>$440,108</td>
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<tr>
<td>July 1, 2016 – June 30, 2017</td>
<td>$197,726</td>
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<tr>
<td><strong>Total – 504 Visits Reviewed</strong></td>
<td><strong>$1,769,695</strong></td>
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</tbody>
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Questions?

Health Care

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