



**UNDERPAYMENT  
RECOVERY**

**CASE STUDIES  
IN EFFICACY**

# TRANSFER DRG

A First-Time Review

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# TRANSFER DRG

## A First-Time Review



### OVERVIEW

Medicare underpayments occur when a patient is discharged as a “transfer,” but there is no post-acute care (PAC) billing. This often happens when a patient decides to forego the recommended PAC after discharge. Accurate transfer coding at the time of discharge is difficult, if not impossible, as it requires that the discharge staff know what the patient will do in the future--not merely what the patient is advised- or intends to do.

Unless a specific underpayment audit is conducted for these cases, the revenue loss will persist and continue to grow.

**In this case study, we will look at one hospital that sought to reclaim Medicare payments through a first-time, four-year retrospective underpayment review.**

### THE CLIENT

The client is a standalone, 47-bed facility in southern Ohio with an average of 430 annual Medicare Discharges, between 2010-2013. The hospital offers a range of patient care services, including emergency, family, orthopedics, and home care.

### SITUATIONAL ANALYSIS

Few would dispute the steady, incremental Medicare revenue stream Transfer DRG underpayment audits can provide; however, for those first-time facilities seeking to implement a long-term solution, the stakeholders must first ask and answer a series of questions to determine the type of solution that would best fit their situation:

***“Outsource to a third-party service, or create a dedicated in-house department to manage the process?”***

Creating and maintaining in-house department is costly, both in terms of time & training, as well as opportunity cost--each time Medicare rules or regulations change, upgrades and training must take place, resulting in lost time and resource management. An in-house team that could return results of the best third-party services would need to be cross-functional and involve IT, database analysts, and billing, coding & compliance personnel. This hospital chose instead to seek a third-party service specializing in Transfer DRG underpayment audits.

***“What are the criteria against which a potential vendor should be assessed?”***

For this facility as for any hospital seeking underpayment recovery services, there are four criteria that must be satisfied:

- 1. A thorough understanding of Transfer DRG rules, security & compliance standards.** Strict HIPAA adherence is, of course, absolutely required. The Centers for Medicare and Medicaid Services (CMS) is responsible for creating and enforcing, through revoked access or the Department of Justice, Transfer DRG rules and regulations. Failure to monitor this landscape and implement changes as needed not only minimizes successful underpayment adjustments, but can also put the company at risk.
- 2. A track record of success.** Transfer DRG success is easily defined: your facility is looking for the service that will provide the most claims and dollars—and quickly. As noted previously, the vendor’s technology will largely determine the number of eligible claims discovered & paid. Not all solutions are created equal.
- 3. Speed and accuracy.** Automated solutions reduce human error and can conduct full, comprehensive reviews of 100% of the claims much more quickly; services that rely largely on manual processes typically “cherry pick” rather than perform full review. For a four-year retrospective underpayment audit, each day that passes can mean more untimely claims and lost revenue.
- 4. End-to-end process management.** Perceived reduced up-front fees can shift costs back to the client; cost benefits gained through outsourcing may be reduced due to the use of in-house resources & training. Services that rely too heavily on RAC audits need to be carefully vetted as well: many services will also look only at a sampling of claims, usually those with the highest potential dollar value, often resulting in substantial missed volume revenue opportunities.

## SOLUTION

The hospital selected Medidal Corporation, a healthcare technology services company that both specializes in the “intelligent” claims automation. Medidal’s track record of success in recovering underpayments that had been missed by other services, as well as the speed with which the data could be reviewed was key. Medidal also offers the end-to-end management of the process, from onboarding the facility’s teams, to handling the data & reporting in a professional and strictly compliant manner. The latter is a particularly important service feature for a first-time underpayment review facility.

## RESULTS

Medidal conducted a comprehensive four-year retrospective review of 100% of Medicare claims between January 2010 and March 2013.

Although the client is a 47-bed facility, Medidal uncovered a 4.96% total underpayment discovery rate across all Medicare claims reviewed. This resulted in over \$170,000 in additional DRG revenue for the hospital.

## ABOUT MEDIDAL

Medidal Corporation is a healthcare technology services company that offers revenue cycle solutions existing healthcare systems were not designed to accommodate. Over the past 10 years, their “intelligent” software algorithms and compliance & insurance expertise have resulted in an innovative suite of product offerings that are best in class.

Medidal has electronic transaction capabilities for Medicare and Medicaid in all 50 states and the District of Columbia. The engineering team practices agile development methodologies, which coupled with rigorous industry & standards monitoring, ensures their Transfer Recovery and Eligibility products remain on the cutting edge of technological innovation and automated revenue cycle solutions.

