SEE YOUR REV CYCLE DIFFERENTLY

UNCOVERING UNDERPAYMENTS IN THE COVID-19 ERA

Choosing the data source to realize faster reimbursement for your hospital

It's always important for hospitals to regain lost payments and maximize reimbursement. But right now, it's critical. Hospitals are continuing to lose revenue due to changes brought on by the COVID-19 pandemic. Plus, the payer mix is shifting due to skyrocketing unemployment while hospitals' fixed costs remain constant.

Because your revenue cycle – and continued operation – depends greatly on uncovering underpayments, your success in this area is crucial. →

WAYSTAR

Use this whitepaper to learn more about:

- Revenue cycle management stressors, including increased underpayments and denials, due to COVID-related care
- How many thousands of dollars hospitals are losing due to underpayments and, how retrospective reviews can help mitigate lost revenue
- How you can get reimbursed faster and more accurately using data from Medicare's Common Working File
- Solutions to worry less about audits and underpayments and ways to strengthen your revenue health – starting today. →

It's always important for hospitals to regain lost payments and maximize reimbursement. But right now, it's critical. The COVID-19 pandemic has caused many headaches for hospitals – and some of them may not disappear anytime soon. As patients have continued to delay or cancel non-essential procedures due to the virus, hospitals are continuing to lose revenue. While the payer mix has shifted due to skyrocketing unemployment and hospitals' fixed costs remain constant, spending on health services dropped sharply and many hospitals have lost revenue, according to the Peterson-KFF Health Tracker report.

In its Q1 earnings report, CVS/Aetna Health reported a steep 30% drop in inpatient services in April 2020, compared with April 2019. Outpatient services saw a 25% decline, and physician services recorded a 35% drop during the same time period. Hospitals lost $202.6 billion between March 2020 and June 2020, according to the American Hospital Association (AHA). The AHA projects that hospital losses between March 2020 and December 2020 will top $323 billion.

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Other pandemic challenges include greater patient volumes and larger numbers of new patients. Higher numbers of patients can result in eligibility problems such as identifying the correct payer and guarantor for COVID-related care, as well as diminish the content and accuracy of insurance information. That, in turn, can result in revenue cycle management stressors, such as increases in underpayments and denials.

Underpayments, especially, are a giant pain point for hospitals everywhere, causing large deficits in their bottom lines. **Underpayment** is the difference between the costs incurred and the reimbursement received for delivering care to patients. It's critical for hospitals to find underpayments and get just reimbursement. Their revenue cycles – and continued operation – may depend on it. How successful a hospital is at uncovering underpayments depends on several things, including the data source and vendor used to help find underpayments and maximize reimbursement.

PACT, DRGs + underpayments

The 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 Policy (PACT). CMS adopted the PACT rule in 1998 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 regardless of their length of stay.

For these cases, CMS determined that the acute hospital should receive a per-diem payment instead of the full DRG rate to account for the short stay. CMS originally identified 10 "high-risk" DRGs for which it said hospitals were discharging patients early and sending them to receive post-acute services to continue their treatment. Now there are 280 Transfer DRGs, and they account for almost 42% of all Medicare discharges, according to CMS.

PACT is triggered when an inpatient claim falls under the following criteria:

1. **The DRG is one of the 280 Transfer DRGs;**
2. **The length of stay (LOS) is less than the geometric mean length of stay (GMLOS) for that DRG; and**
3. **The patient was discharged to a qualifying post-acute facility, such as a home health agency or skilled nursing facility.**

If all three criteria are met, CMS will automatically apply a per-diem payment to the claim to account for the short stay.

Discharge status codes figure largely into the Transfer Rule and Medicare's calculation of hospital reimbursement. The discharge status code is assigned by the hospital based on the anticipated treatment, if any, after the patient leaves the hospital. Only certain discharge codes are impacted by the Transfer Rule. If the patient receives post-acute care, such as at a home health facility, he or she should get a transfer discharge status.

Errors can occur with discharge status assignment, and that can result in underpayments. For example, when patients are not treated according to plan after being transferred, or when a claim is given an inaccurate discharge status code, it results in an underpayment in the transferring hospital's Medicare payment. Sometimes, a hospital doesn't always have enough information to make the proper assignment, or home health care may be planned but the patient makes a different decision.

If the post-acute provider didn't receive payment and the short-term acute provider received partial payment, Medicare underpays on that account. If the transfer to postacute did not take place or did not happen under the terms CMS has set forth, then the short-term acute care facility is entitled to the remaining DRG payment amount.

The importance of finding underpayments

The Office of Inspector General's November 2019 audit 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 postacute care.

When CMS performs an audit, it's important to note that it is primarily looking for cases where hospitals have discharged a patient to home as a non-transfer. CMS audits have been strictly focused on overpayments to hospitals. Hospitals are on their own to detect any underpayments. It's a good idea for hospitals to find underpayments, however, as Medicare's Transfer Rule typically results in billions of dollars in reduced and lost revenue for hospitals each year.

In 2017, in fact, Medicare underpayments totaled almost $54 billion, according to the AHA. Other industry estimates show that as much as 12% to 15% of Transfer DRG claims go underpaid. According to Waystar's data, the average hospital is losing hundreds of thousands each year due to Transfer DRG underpayments.

The audit created a stir among hospitals when it was released last year. It found that hospitals were significantly overpaid. As a result, CMS implemented edits to help prevent overpayments in the future. Hospitals began worrying about their risk of takebacks and whether using Transfer DRG services to find underpayments could increase that risk.

According to Waystar's data, the average hospital is losing hundreds of thousands each year due to Transfer DRG underpayments.

If a hospital believes a patient is being discharged to home but, in fact, the patient includes home health or skilled care, a hospital may be overpaid. As a result, the Medicare Administrative Contractor (MAC) will identify this in the claims data and take back the entire original payment, not just the difference between the original amount and the Transfer DRG payment amount. The hospital then should submit a claim adjustment to reflect the correct discharge status. CMS audits don't look for or find underpayments. Hospitals are on their own to investigate discharge status code assignment and detect underpayments.

There are several ways providers can find underpayments. Over the past few years, CMS has developed the Recovery Audit Contractor (RAC) program to identify overpayments and underpayments, including those impacted by the Transfer Rule. However, the RACs identify underpayments through a computer algorithm that doesn't validate the level of care with post-acute providers. This means the RACs are recovering Transfer DRG underpayments that are not in compliance with Medicare regulations.

Third-party vendor reviews also can help uncover underpayments. Retrospective reviews can be conducted for up to four years after a previous claims was submitted.

CWF vs EHRs

Started in 1989, the **Common Working File (CWF)** is the system used by CMS to verify a Medicare beneficiary's entitlement to and correct use of Medicare benefits. When an individual signs up for Medicare, the government creates a record for him or her in the CWF. The CWF contains each patient's national Medicare record. These records are a detailed account of each Medicare beneficiary's status and the services that he/she has received. CWF includes a patient's entire Medicare history, from every facility that has treated the patient.

Some of the data documented in the CWF includes:

- **Entitlement to Medicare Part A and Medicare Part B**
- **Date of birth and date of death**
- **Part A and Part B blood deductible information**
- **Benefit periods and days remaining in the current benefit period**
- **Beneficiary claim history**
- **Hospice and/or MAO plan enrollment**
- **Primary payer insurance coverage when Medicare is not primary**
- **Preventive services**

An **Electronic Health Record (EHR)** contains a patient's health information from a particular healthcare facility in a digital format. These records can be shared across different healthcare settings. An EHR makes health information instantly accessible to authorized providers across practices and health organizations. EHRs contain a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and lab results, among other medical information. EHRs provide critical data that may influence clinical decisions and help coordinate care among all healthcare providers and systems.

EHRs report information from one facility, not a patient's entire medical history spanning multiple facilities. EHRs don't report what happens after a patient leaves one facility and goes to another.

For years, using EHRs was the only available option to identify underpayments. However, piecing together information from different EHRs results in a patchwork of medical records without seeing the full history.

Why is the data source important?

Within the walls of the hospital, the hospital's EHR is the golden patient record, but once the patient leaves the hospital, their care record in that EHR stops. The discharge plan documents what is supposed to happen, but it doesn't always document what actually happens. If the patient received post-acute care, that record of care is then siloed in the post-acute care provider's EHR – but that EHR is different from the hospital's EHR. Piecing together what happened during the patient's journey via different EHRs results in a patchwork of medical records, none of which presents a complete history.

In contrast, when a patient is a Medicare beneficiary, Medicare keeps a full longitudinal record of that beneficiary's care throughout the claim history of that beneficiary. This claim history crosses all care facilities and represents the patient's care journey.

The CWF holds the full history of what happened to the patient prior to admission and after discharge. It can answer key questions about the patient such as:

+ **Did he or she make it to the SNF?**
+ **Did he or she have Home Health services prior to admission?**
+ **Did he or she get Home Health services after being discharged, but not within the three-day time limit required by CMS?**
+ **Did the patient just go home?**

The CWF makes reviewing a large amount of claims quick and easy, but is one data source – either CWF or EHRs – better or more accurate than the other?

Medicare uses the CWF as its source of truth in its audit processes while healthcare providers tend to rely more on EHRs. EHRs are the source of truth for hospitals, but CWF is the source of truth for Medicare because it encompasses a patient's entire medical history and follows each patient from facility to facility.

EHRs don't know what happens after a patient leaves their facility; however, the CWF is not always a better source than EHRs. It just depends. For example, in situations related to revenue cycles and Medicare, CWF is the best source. For coding issues, EHRs often are the best source because they are the source of truth for clinical data and records. Healthcare providers should keep in mind that Medicare relies on the CWF to adjudicate claims. Recovery Audit Contractors (RACs) use CWF data, as well, to perform automated reviews to identify PACT-related overpayments. Access to the CWF also allows providers to find RTPs and Additional Documentation Requests.

For these reasons, providers may get reimbursed faster and more accurately using CWF data. It likely will take longer if a provider or a vendor relies on EHRs as their source of truth. CWF is simply a better overall view of a patient's care history from day one. With Medicare data, there are no surprises.

Waystar's Transfer DRG technology

In the current environment, hospitals must discover and recover every dollar they earn. That's why finding underpayments is so critical.

Some third-party vendors may employ clinical staff to review patient records and call post-acute care facilities directly to try to find underpayments. They may rely on EMR patient records cross-referenced with post-acute billing as the source of truth, instead of using the CWF.

Waystar is different, however. As a Medicare Network Service Vendor (NSV), we have direct access to the CWF that others don't have. Our technology, paired with accessing the Medicare system directly, provides the most accurate representation of what took place after a patient was discharged from the hospital.

As a Medicare NSV, Waystar can see the full history of what happened to the patient prior to admission and after discharge. We use this insight to search for underpayments and also notify the provider of any overpayments we uncover. Waystar is the only NSV who offers a Transfer DRG service currently.

How does our solution work?

$3,500
Average reimbursement

$1+ BILLION
revenue recovered

0
PACT violations

99.54%
Clean claim rate

0.46%
CMS denials

Using the CWF as our data source, Waystar's Transfer DRG technology helps boost providers' cash flow and reduce audits.

Here's how it works: We compare all accounts to the patient data available in the CWF after an account has aged six months. This provides a large enough window for a post-acute facility to file a claim for a discharged patient.

As an NSV, we access FISS and the CWF directly to review the patient's account details and cross reference the information. Our Transfer DRG technology analyzes the data and identifies areas of opportunity to adjust codes for payment. When a provider approves the reported claims, our team of experts adjusts the claim directly in the CWF/DDE. Our clients begin seeing revenue within two-to-four weeks of the adjustment.

Our end-to-end automated process captures the full DRG reimbursement and then adjusts the claim in the CWF/DDE.

Waystar's Transfer DRG works well alongside Medicare Enterprise, our all-in-one solution manages your Medicare revenue cycle. It includes reporting and analytics, claims correction, eligibility verification, and reliable file transfer. With our Medicare Enterprise package, worry less about audits and underpayments, and start strengthening your revenue health.

When to use which source?

CWF

Registration

Once claim is gone

Post-review audit

Transfers

Find RTPs and ADRs/claim review

Fund certain claims

EHR

Data to create a claim

Facility data

Patient timeline

EXPLORE OUR ALL-IN-ONE PLATFORM

Patient Financial Clearance

Verify insurance coverage to reduce claim rejections and denials

Revenue Integrity

Find missing charges and capture revenue you're due

Claim Management

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

Denial Management

Prevent denials and automate appeals

Patient Financial Experience

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

Agency Management

Get insights into outsourced agency effectiveness

Patient Insights

Use data on broad factors that influence health to improve clinical outcomes

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ABOUT WAYSTAR

Waystar simplifies and unifies healthcare payments with innovative, cloud-based technology. Together, our technology, data and client support streamline workflows and improve financials for our clients, so they can focus on their patients.