
CorroHealth

From Denials to Recovery: Upgrading Your Approach to DRG Downgrades

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Overview

Identification of DRG Downgrades

- The evolution of DRG Downgrades
- How and why DRG Downgrades are difficult to recognize and quantify
- Impact on hospital revenue can be significant

Comprehensive Approach to Combat

- Recording essential data points
- Structuring appeals with the right resources using a cross-functional approach
- Leveraging all appeal levels and rights

Gain Valuable Insights

- Strategies to minimize DRG Downgrades
- Internal process and documentation improvement
- Contract language protections

Defining DRG Downgrades

When a patient is admitted as an inpatient to a hospital, that hospital assigns a DRG upon discharge, basing it on the diagnoses the physician documented during the hospital stay. The hospital then gets paid a fixed amount for that DRG.

Downgrading occurs when the hospital-billed DRG is changed by the payer or 3rd party audit firm to a lower-paying DRG by removing CC/MCC diagnosis codes

(DRG's are never "upgraded.")

Evolution

The Evolution of the DRG Downgrade

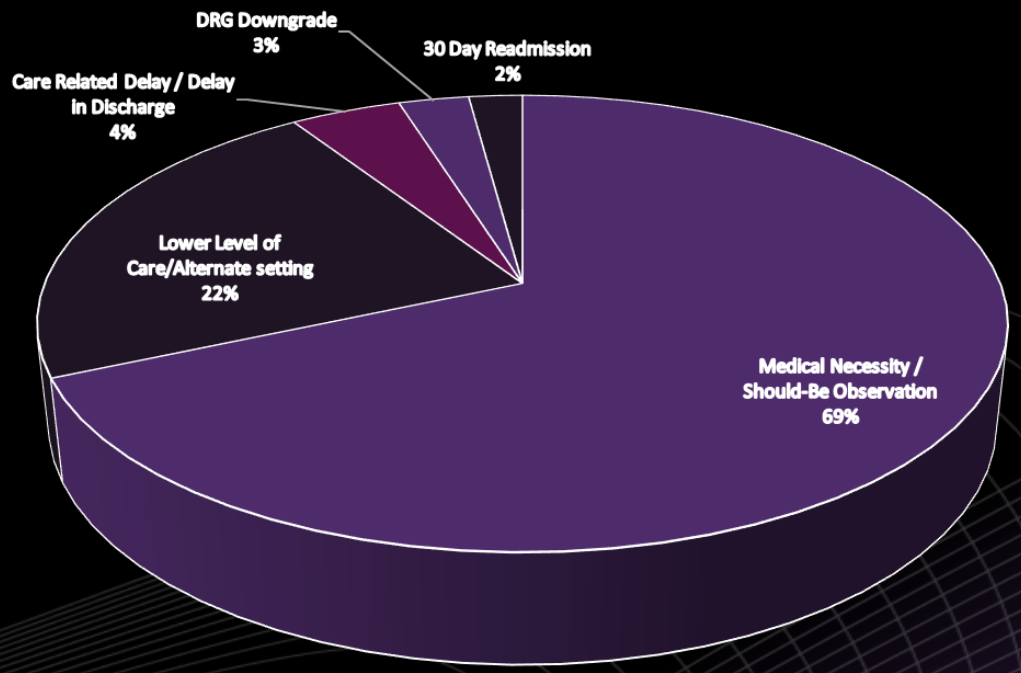
DRG Downgrades are not "new," but the nature of the downgrade has changed over the last decade

Diagnosis Codes - From billing errors (Technical Denials) to a question of clinical validation (Medical Necessity Denials)

Why this change? Considerable denial increases and reimbursement decreases

Impact

A Growing Problem



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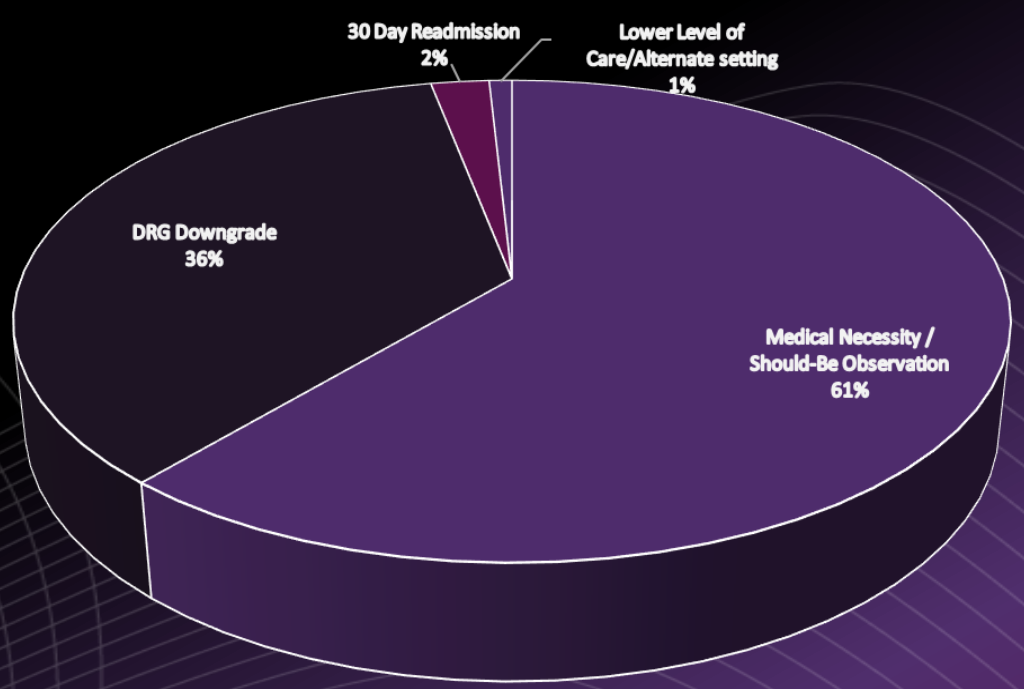

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Identification

DRG Downgrades Are “Hidden Denials”

Pre-Payment vs. Post-Payment, Audit Firm vs. Payer, issuance is virtually always in the form of a paper letter (often sent to HIM, bypassing PFS)

835's/EOB's are unreliable and almost never include a CARC code indicating the claim is partially denied. Further, they rarely include the DRG being paid. Why?

Case Example

835 …	# TOB	DRG	Total Charges	Amount	Date Paid	
08/25/22	1 111	659	$36,147.45	$22,971.20	08/30/22	Initial Payment
08/30/22	1 111	659	$36,147.45	$865.32	08/30/22	IME/Sequestration
04/11/23	1 111	659	-$36,147.45	-$22,971.20	04/14/23	Recoupment
04/11/23	2 111	659	$36,147.45	$12,854.96	04/14/23	Downgraded Payment

Claim Details

Claim Start Date	Claim End Date	Billed Charges	Allowed Amount	Ded	Co-ins	Copay	Other PR	Adj	CARC	CAGC	RARC	Payment
08/06/2022	08/08/2022	$36,147.45	$17,526.00								N59	$12,854.96
Total Claim Adjustments		**$36,147.45**	**$17,526.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				**$12,854.96**

CLAIM ADJUSTMENT REASON CODE DEFINITIONS

253: Sequestration - reduction in federal payment

45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)

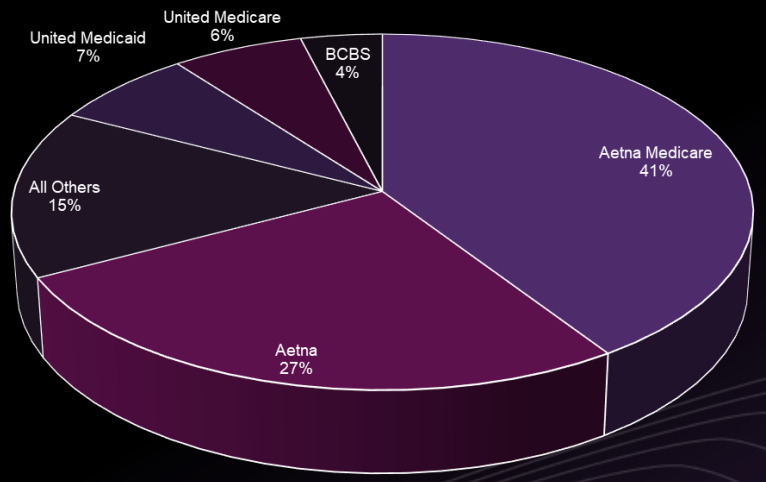
97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110

REMARK CODE DEFINITIONS

N59: Alert: Please refer to your provider manual for additional program and provider information.

The Who

Payer Evolution



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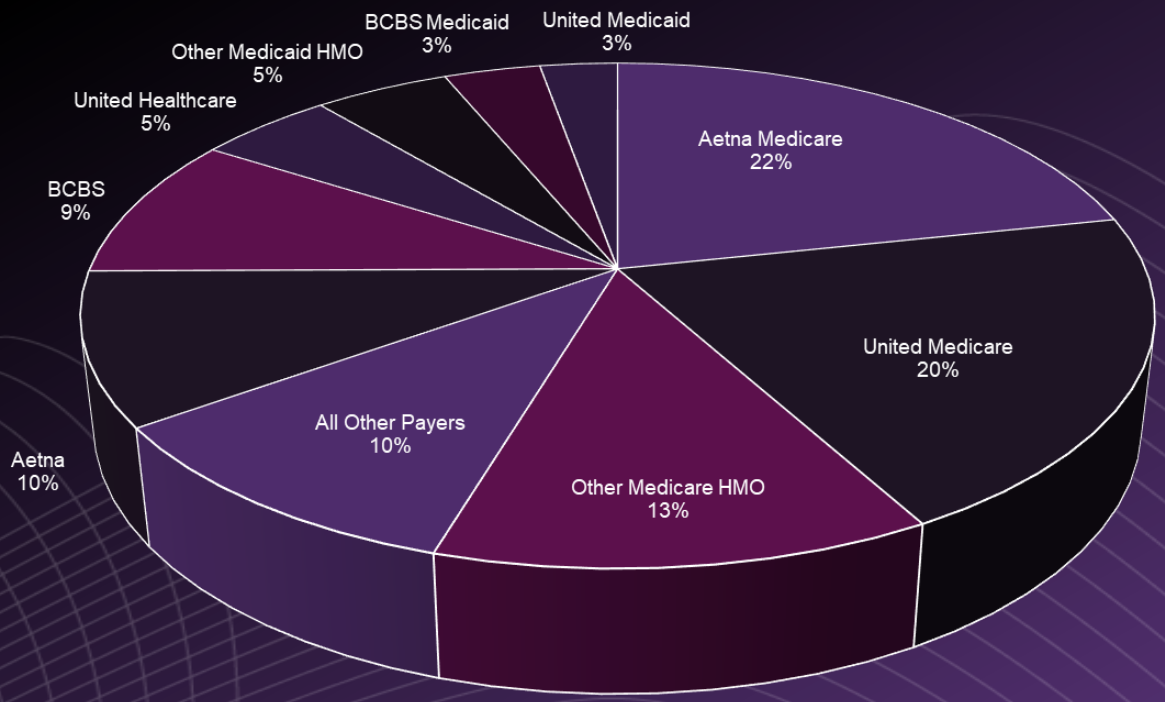

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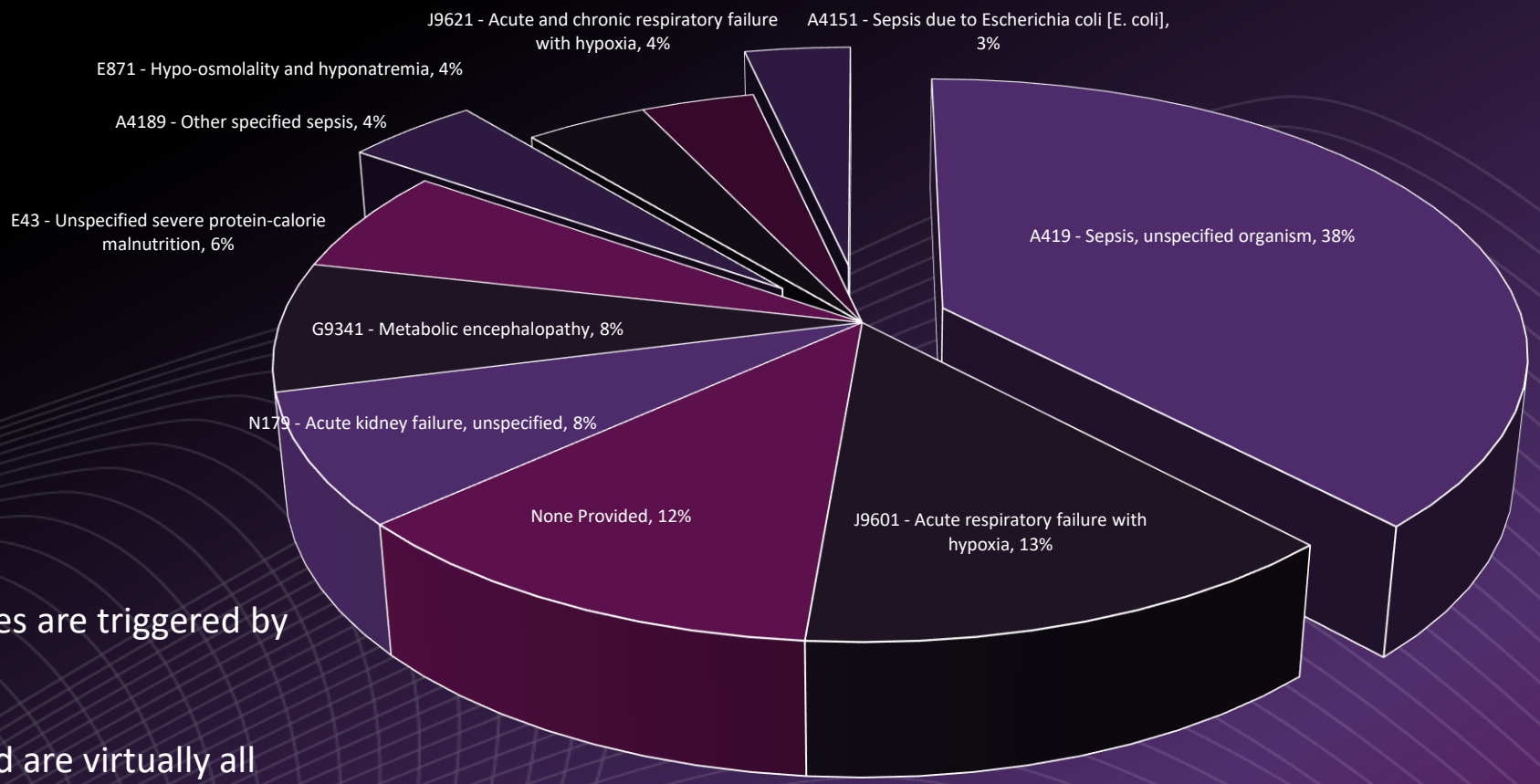
The "problem payers" list is growing and changing. Aetna has historically been the most aggressive in the local market; however, more and more payers are following suit.

Further, 65%+ of downgrades are initiated by 3rd party audit firms, which can leave even the payer in the dark during the audit process.

The How

Diagnosis Codes



- Almost 50% of downgrades are triggered by a Sepsis DX code
- The top DX codes targeted are virtually all MCC's that can significantly impact the CMI/reimbursement associated with the encounter

Why Sepsis?

Sepsis 2 vs. Sepsis 3

In 2016 a new definition of sepsis and septic shock was published.

- According to Sepsis 3, patients are required to have sepsis in combination with a rise in **sequential organ failure assessment score (SOFA) of at least 2 points**
- In contrast, for patients to comply with the previous Sepsis 2 definition, they needed to have sepsis in combination with at least **2 systemic inflammatory response syndrome (SIRS) criteria**

	SIRS	qSOFA
Temperature	X	
Heart Rate	X	
Blood Pressure		X
Respiratory Rate	X	X
Oxygen Saturation		
Use of Supplemental Oxygen		
Mental Status		X
Leukocyte Count	X	
Urine Output		

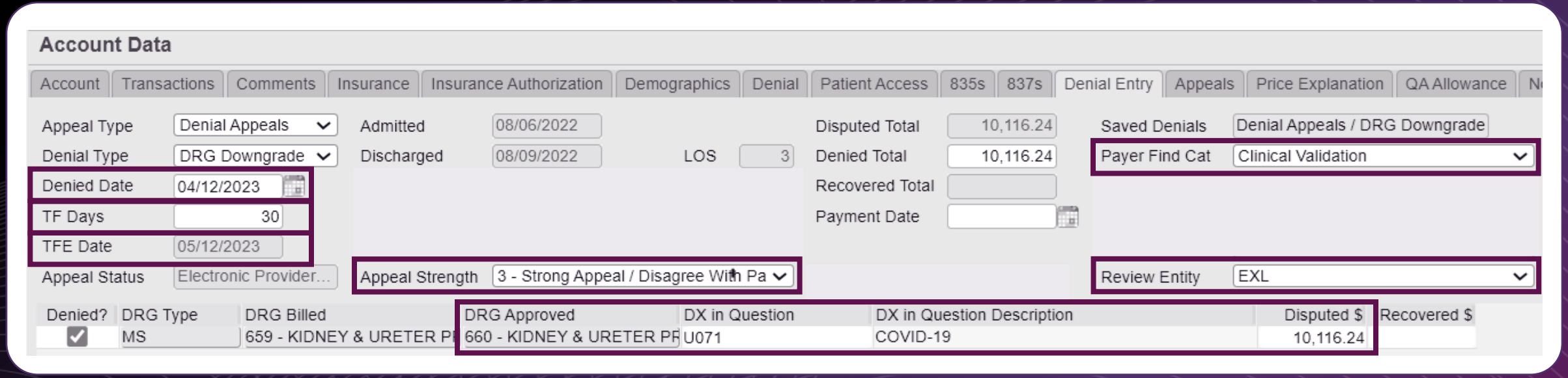
Why do Payers Prefer Sepsis 3?

- Studies have shown that QSOFA has a higher level of specificity, which is helpful in filtering out false-positive Sepsis patients ***in a research setting***
- In a healthcare setting, QSOFA does not adequately replace SIRS and could result in patients with early Sepsis failing to qualify for early interventions
- 20% of patients meeting Sepsis 2 criteria will not meet Sepsis 3, thus falling to a lower CMI DRG
- The average net reimbursement difference once Sepsis as a DX has been removed can be upwards of $100k (averaging around $8k per case across all payer types)

Appealing Effectively

Record the Data and Allocate the *Right* Resources

- Coders + Clinician Resources = Success
- HIM teams are inundated with downgrades and the best appeals require a clinical validation review (RN or MD)
- If the right resources are difficult to allocate internally and outsourcing is a current or future option, ensure your vendor is using clinicians (RN/MD with coding experience a plus) to work DRG Downgrades



Draft More Successful Appeals

- CorroHealth's appeal process has dramatically increased recovery rates for our hospital partners.
- Education and feedback are key.
- We have recovered >$50 million for our clients using this method.

1. Conduct a Coding Review along with specific references to coding guidelines to show that the case was coded accurately. *(Coding alone is rarely the root cause of these denials, but weed the true coding issues out at this phase)*
2. Summarize the patient's relevant past medical history and overall medical necessity of the case
3. Provide support to show that the dx code(s) prompting the downgrade were relevant and resulted in more complex/costly treatment to their member. Use CMS guidelines solidified by the 4201 final rule when appealing to Managed Medicare plans

Bolster Your Sepsis Appeals

- Cite who diagnosed sepsis in the patient medical record. Include physicians from the ED, hospitalists, critical care, infectious diseases, surgeons, and wound care. Include their specialties and their qualifications to diagnosis sepsis.
- List their identified risk assessments, including immunosuppression, uncontrolled hyperglycemia, hemodynamic instability, MAP scores, etc. Point out a consensus of the diagnosis within the progress notes, H&Ps, and consults.
- Reiterate that hospitals do not diagnosis sepsis, clinicians at the bedside do.
- Were hospital resources used to treat the patient's sepsis? If so, according to the E/M coding world, only a practicing clinician who evaluates and treats the patient, and who diagnoses, treats, and measures the response to therapy is qualified to diagnose it.
- Cite recent articles that support your case.

Strategies

The Best Defense is a Good Offense

- Do not change the DX/DRG coded unless you agree the root cause was a true coding error (undocumented DX was coded)
  - Coders must code based off physician documentation - Utilize physician queries whenever helpful
  - If the claim is re-coded and billed to the downgraded DRG, integrity of the denial is lost
- Do not sign-off on audit letters
  - Signing off is essentially agreeing with the downgrade and waives your right to future appeals/escalation/arbitration
  - The payer does not need a new claim - the DRG will be downgraded automatically if appeal is unsuccessful
- Timely Appeal Filing guidelines may differ for DRG Downgrades
  - Downgrades resulting from post-pay audits generally allow for 30-60 days pre-recoupment (to audit firm) and an additional 60-360 days post-recoupment (directly with payer) – maintain your contractual rights to appeal directly with the payer
- The person reviewing your appeal with the audit firm may be under-qualified - this will not hold up if 3rd level appeal rights are available

DRG Downgrade Prevention

- Ensure documentation of diagnosis is consistent and non-conflicting throughout the chart
  - Case Study example will follow

Contract Language Recommendations

- **Limits on the % of admissions that can be subject to DRG audit**
- **Prohibition of the use of 3rd party audit firms**
  - A case can only be audited by the payer directly
- **Expertise level of clinician reviewing the case on the payer-side should match the care patient received on the hospital-side**
  - For example, a pediatric physician should not be justifying a denial for an adult cardiovascular patient

Case Study

Case Study: DRG Downgrade Denial

Billed DRG	853 - INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC
Downgraded DRG	660 - KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC
Denied Dollars	$33,872
CorroHealth Review	No Appeal – Documentation Conflicting
DX Code Trigger	A419: Sepsis, unspecified organism

HOSPITAL COURSE BY PROBLEM

1.Left obstructing ureteral stone
pt pw sudden onset L flank and LLQ pain, aw NV and increased urinary frequency, urgency. No fever/chills or dysuria
CT a/p on admit showed *moderate L hydroureteronephrosis 2/2 obstructing UPJ stone, 16 x15 mm. Addl intrarenal calculi in lower posterior pole up to 2 cm*
Urologist Dr a Cystoscopy. Foley and Ureter Stent was placed.
Home with foley. Follow up. For Possible Stent exchange Vs extraction.
Cardiology follow up for Clearance.

2. SIRS
T 101.2, HR 90s and WBC 11.5-->10.6
Sepsis ruled out. Continue Prior Home IV antibiotics for Discitis.

3.AKI
Creat 1.7-->2.1 today, up from prior BL ~1-1.2. Thought likely postrenal in setting of obstructing stone.
Anticipate improvement following stent
Improved serum creatinine with kidney drainage and IVF.

4.Hyponatremia- mild 130s, trending on IVF

Case Study: DRG Downgrade Denial

Physician Query

Dear Dr.

--Noted in the Sepsis Screening Tool by NP on 10/3: Sepsis ruled out

--10/3 Noted in Consult Note: Sepsis secondary to urinary source

--SIRS criteria on admission: WBC 13.00, HR >90

--PTA and current treatment with Daptomycin and Rocephin for L5-S1 discitis

Please clarify conflicting documentation in the medical record.

[x] Sepsis is the valid diagnosis for this admission

[ ] Sepsis ruled out

Questions?

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