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How to Upgrade Your DRG Downgrade Game

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Denials Task Force - What's First?

- Growing high-dollar denial issues should be a main target of any institution's Denials Task Force
- Quantifying denials based on 835's will miss huge pockets of audits coming in paper form, often 1-2 years post service date.
- Capture and record those audits as denials. You may find they are your highest dollar issues

This presentation will educate on the who, what, when and why of DRG Downgrades. Plus, a step-by-step plan of attack.

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Watch Our Webinar On Demand

The “Combatting Denials With Special Forces” Webinar is now available. For Annabelle and Lindsay's insight on how to build a successful Denial Task Force, follow the link below to access the recording -

https://info.versalushealth.com/mapamwebinar

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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 to a lower-paying DRG (DRG's are never "upgraded").

Evolution

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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 relevancy/protocols met (Clinical Denials)
- Why this change? Considerable denial increases and reimbursement decreases

Impact

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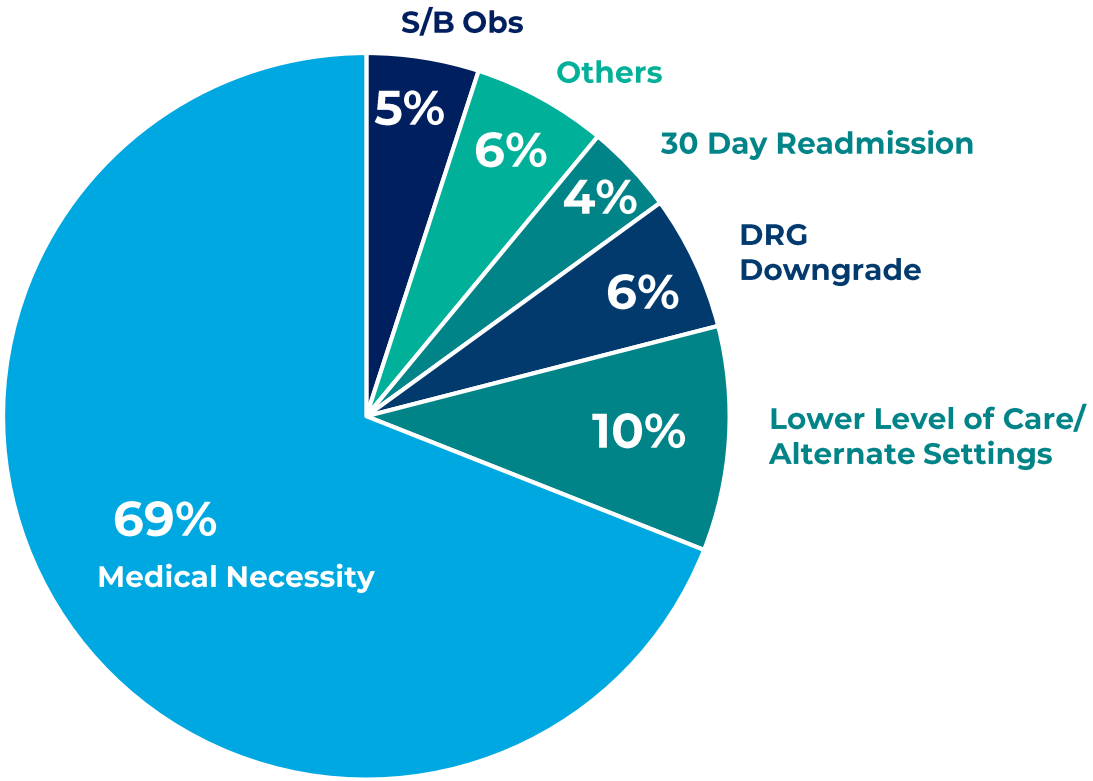
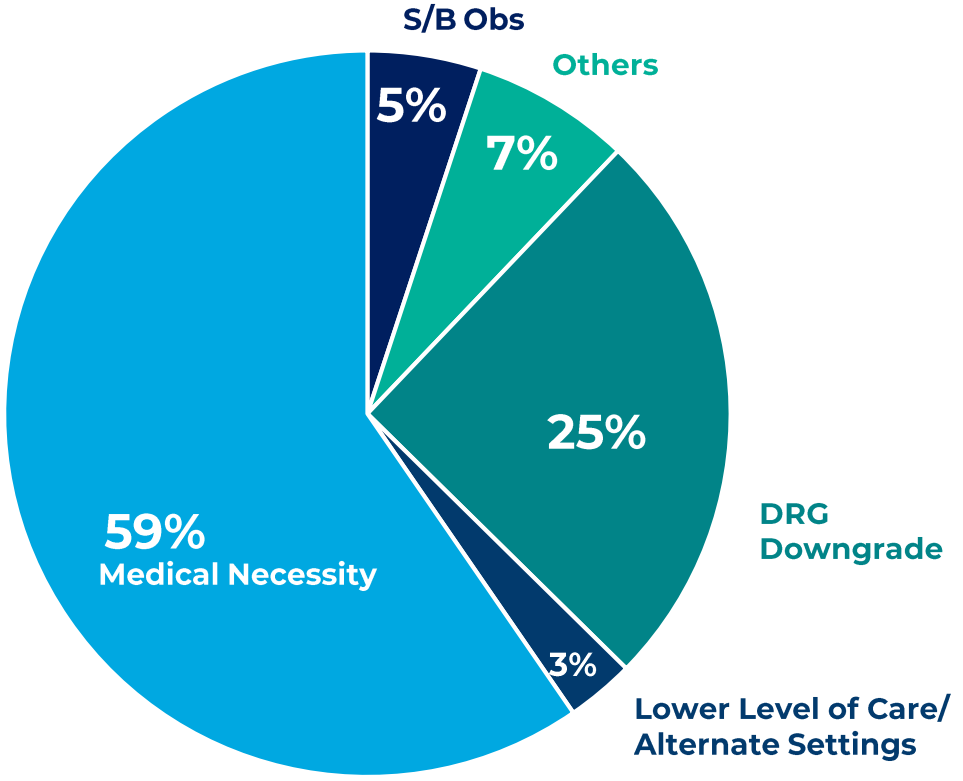
DRG Downgrades as a % of Denials

2018



2020



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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?

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The Who

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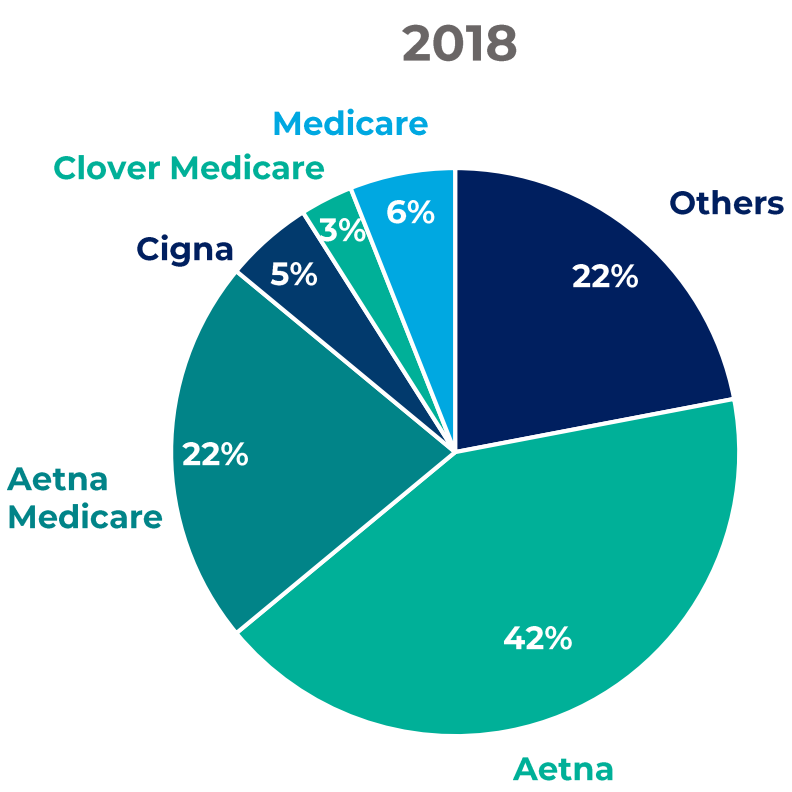
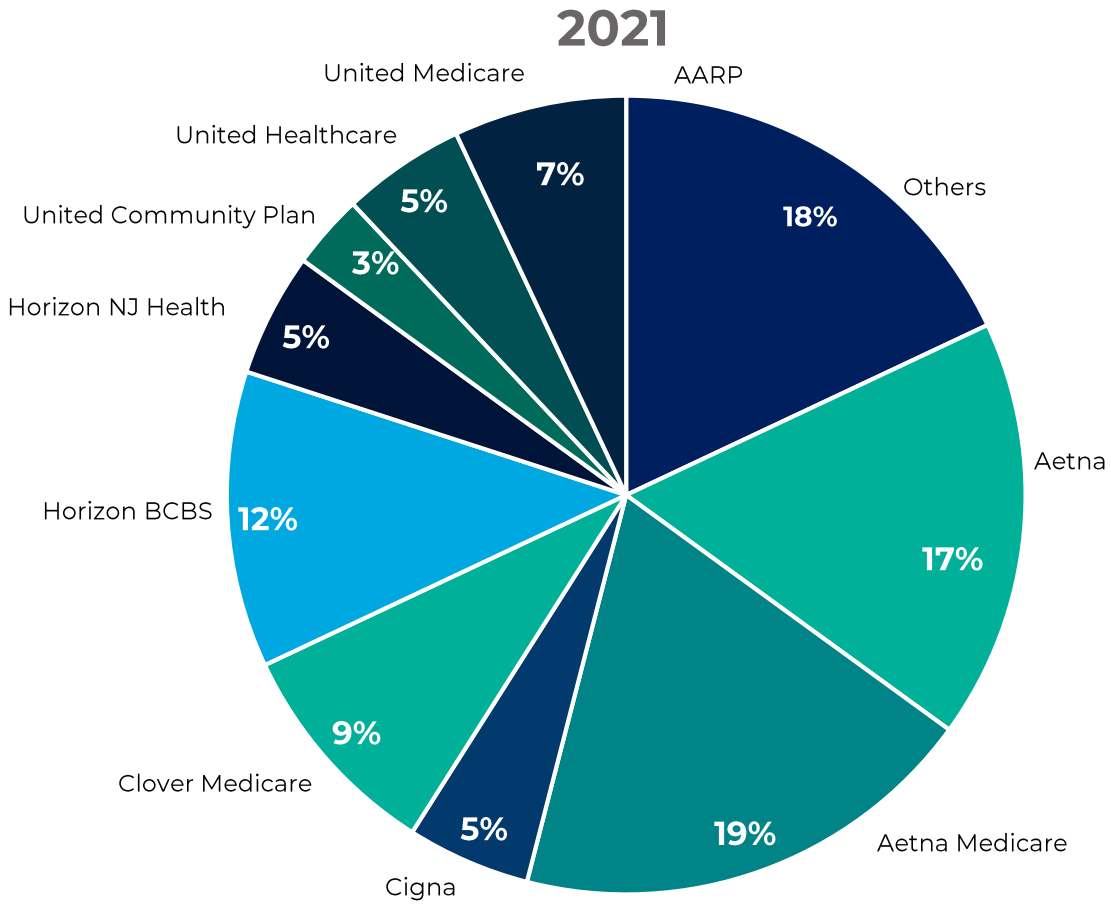
Payer Evolution

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, 56%+ of downgrades are initiated by 3rd party audit firms, which can leave even the payer in the dark during the audit process.





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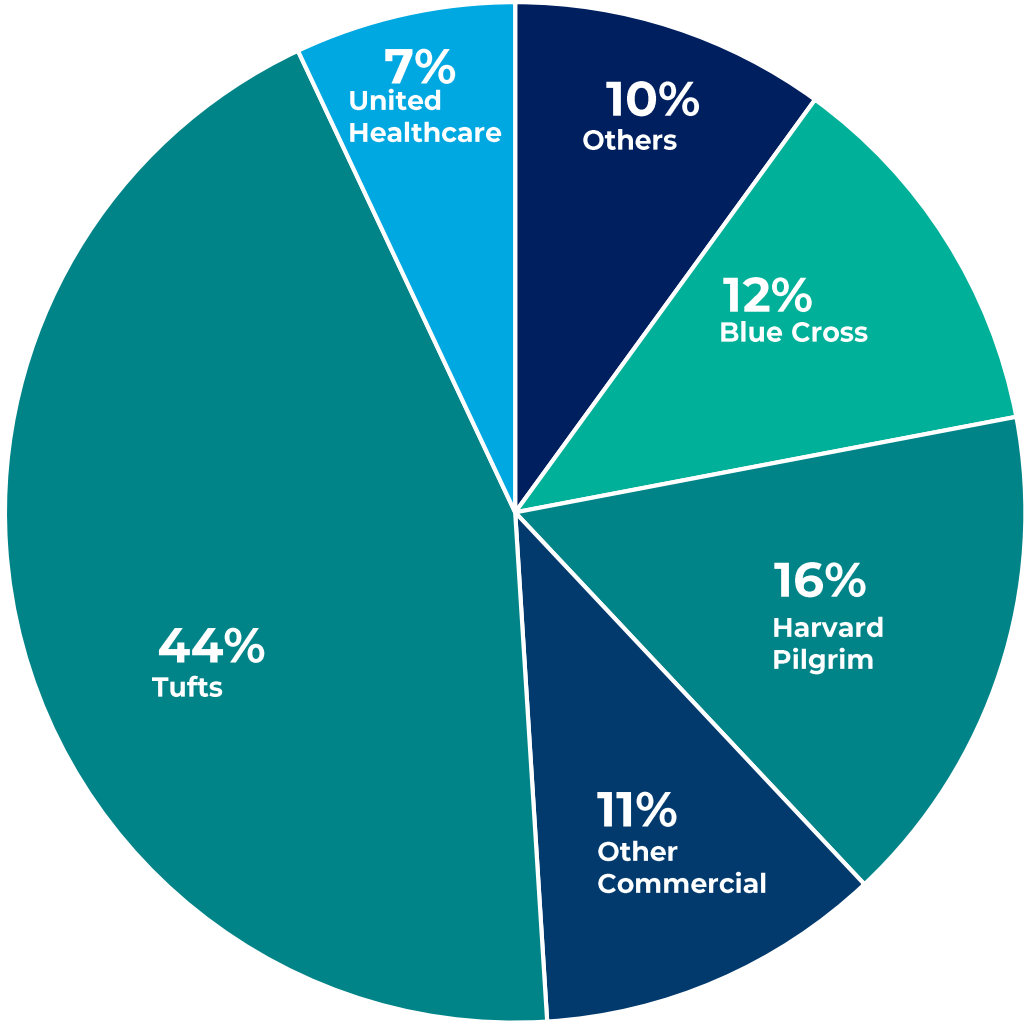
Massachusetts Downgrades



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The How

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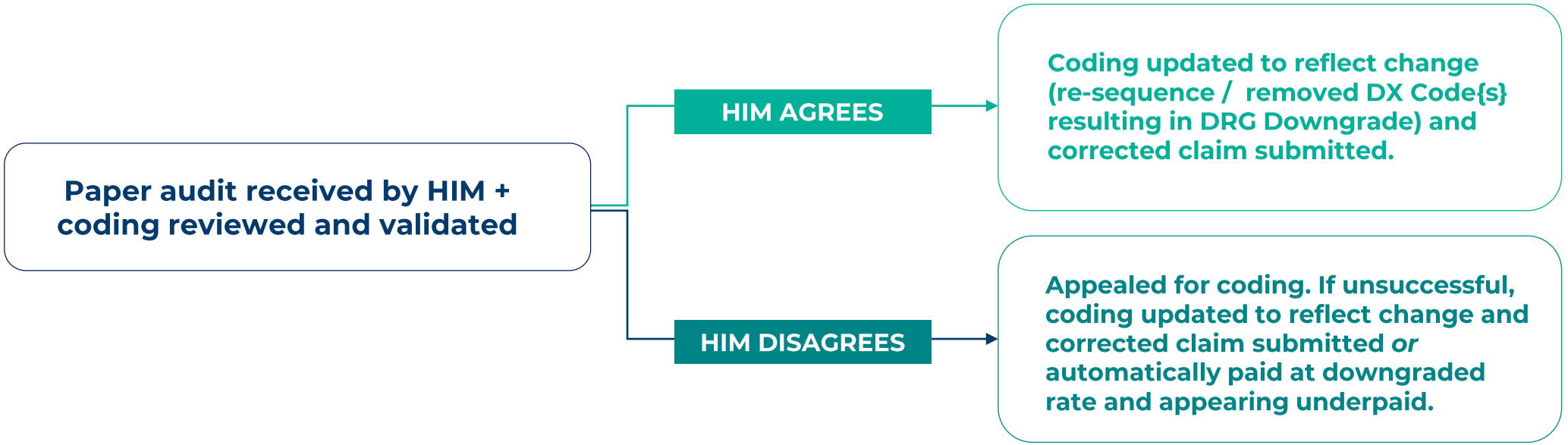
Downgrades can be Difficult to Quantify Depending on the Internal Procedures Being Followed

- Historical HIM decision tree, although well meaning, can create more of a hidden mess
- Average net reimbursement difference between billed and downgraded DRG is $9,000+



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The Triggers

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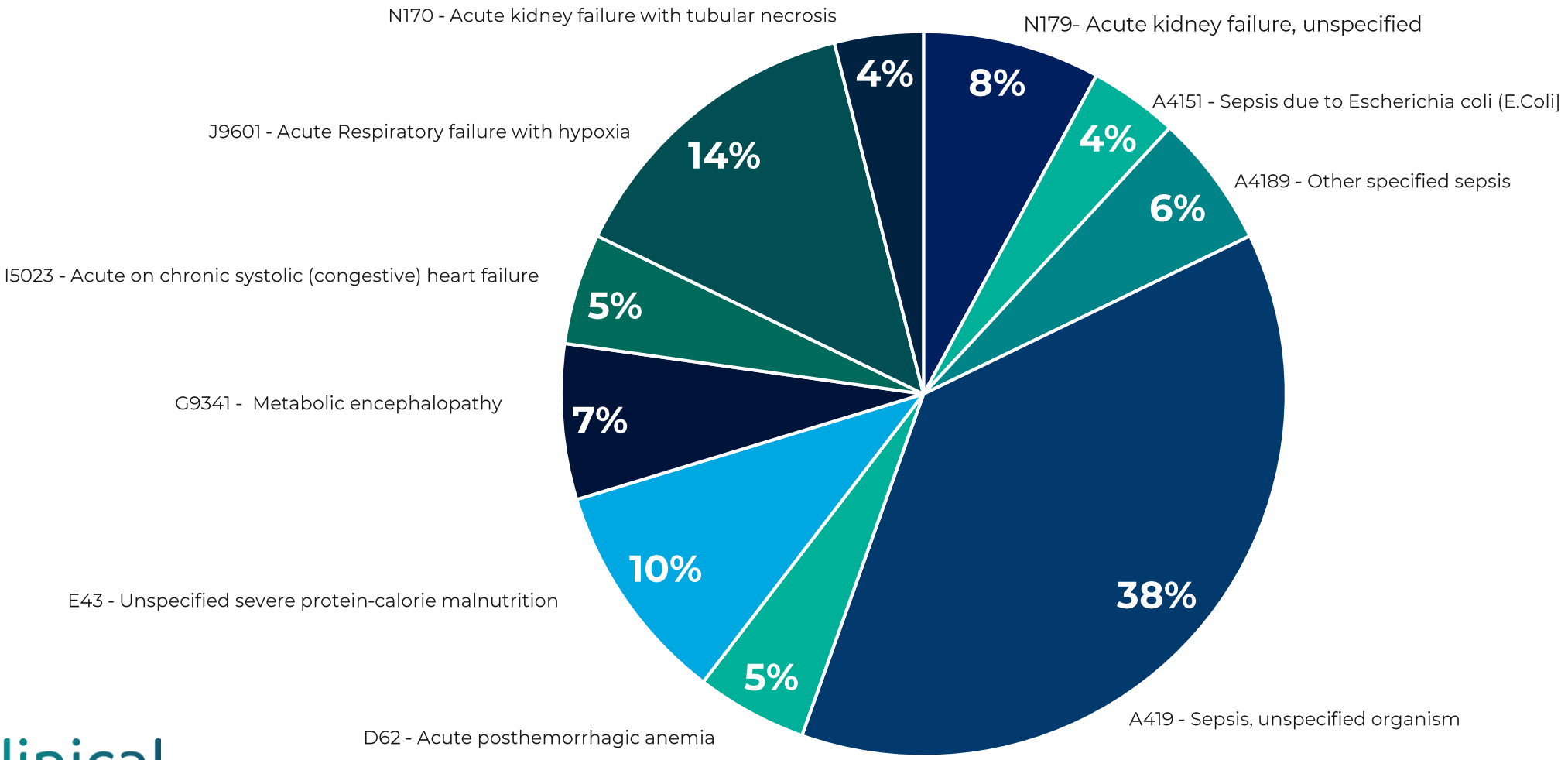
Diagnosis Codes

- 48% of downgrades are triggered by a Sepsis DX code
- "Unspecified" and "Acute" conditions are also commonly questioned



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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**

Approximately 20% of the patients meeting Sepsis 2 criteria do not qualify for Sepsis 3

	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		

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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 would result in patients with Sepsis failing to qualify

Sepsis 2 saves more lives, Sepsis 3 results in 20% fewer Sepsis diagnoses and a significant reduction in potential reimbursement

Case Study →

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Case Study

Sick Patient Presents to the ED...

Triage assessment shows the patient to have:

Elevated Temperature
Elevated Respiratory Rate
Elevated Heart Rate

Criteria Met:

- Sepsis 2 = YES (3 of the required 2 SIRS points)
- Sepsis 3 = NO (only 1 of the 2 required QSOFA points)

Appealing Effectively

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The Best Defense is a Good Offense

Start by Knowing Your Rights

- **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 of physician documentation
  - Utilize physician queries
- **Appeal and future arbitration rights will be lost if the DRG is changed and re-billed**
  - Further, denial tracking and reimbursement difference would be lost
  - 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 60 days pre-recoupment (to audit firm) and an additional 60-180 days post-recoupment (directly with 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**

The Winning Appeal

Corro Clinical's appeal process has dramatically increased recovery rates for our hospital partners.

Education and feedback are key.

We have recovered over **$20 million** for our clients using this method.

Coders + Clinician Resources= Success
HIM teams are inundated with downgrades and the best appeals require a clinician review

1. Summarize the patient's relevant past medical history and overall medical necessity of the case
2. Include 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)*
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

If the right resources are difficult to allocate internally, ensure your denial vendor is using clinicians (RN with coding experience a plus) to work DRG Downgrades.

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Bolstering 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.

QUESTIONS?

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