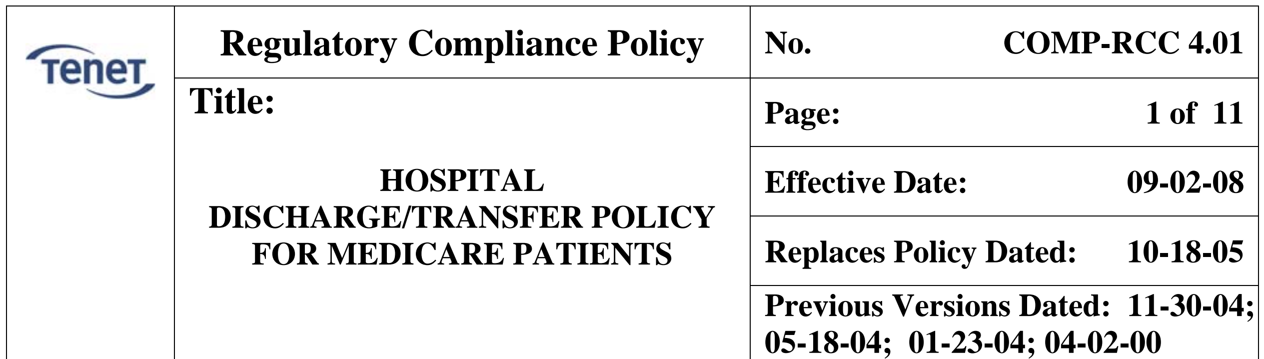


	Regulatory Compliance Policy	No. COMP-RCC 4.01
Tenet	Title: HOSPITAL DISCHARGE/TRANSFER POLICY FOR MEDICARE PATIENTS	Page: 1 of 11
		Effective Date: 09-02-08
		Replaces Policy Dated: 10-18-05
		Previous Versions Dated: 11-30-04; 05-18-04; 01-23-04; 04-02-00

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of 50% or more; and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively "Tenet").

II. PURPOSE:

The care for a patient in a facility typically ends with the discharge, transfer, or the death of the patient. The decision to and timing of discharge/transfer is the responsibility of the attending physician and is based solely on the physician's assessment of the patient's medical condition/medical needs.

Tenet is committed to assuring that discharge/transfer decisions are properly carried out and that Medicare claims accurately reflect the discharge/transfer status of the Medicare patient. Furthermore, although this policy clarifies Medicare billing requirements concerning the discharge/transfer of Medicare patients, all discharge/transfer decisions must be consistent with all state and federal laws, including but not limited to, the Emergency Medical Treatment and Labor Act (EMTALA).

Each Tenet Facility is required to use established discharge/transfer screens as defined in the facility's Utilization Management Plan ("UM Plan") to assist the physician with discharge/transfer planning to assure clinically appropriate disposition of the patient. The circumstances surrounding the discharge/transfer of an inpatient may affect the payment due to the facility from Medicare for the care rendered on a fee-for-service basis. It is essential that the Tenet Facility follow the procedures set forth below, so that Medicare claims for inpatient services comply with the requirements established by the Centers for Medicare & Medicaid Services (CMS). This issue also may arise for Medicaid programs that make payment on the basis of DRGs.

III. DEFINITIONS:

A. A "discharge" occurs when a Medicare beneficiary (i) leaves a Medicare Inpatient Prospective Payment System (MIPPS) acute care hospital after receiving complete acute care treatment or (ii) dies in the hospital.

B. A “transfer” occurs when a Medicare beneficiary in a MIPPS hospital is (i) transferred to another acute care MIPPS hospital or unit for related care or (ii) discharged but then readmitted the same day to another MIPPS hospital, unless the readmission is unrelated to the initial discharge. Patients who leave the hospital against medical advice (LAMA) are treated as transfers if the patient is subsequently readmitted to another IPPS hospital on the same day.

C. A “qualified discharge” is a discharge that is treated as a transfer for Medicare payment purposes. This occurs when a beneficiary whose inpatient hospital stay is classified under one of the designated transfer DRGs , receives care from a home health agency within three days of discharge, or is admitted to a Medicare-certified skilled nursing facility (SNF) for related care, even if the services provided by the SNF are not Medicare covered, or is admitted to a hospital or hospital unit that is not reimbursed under MIPPS, e.g., a long-term care, cancer, or children’s hospital or a psychiatric or rehabilitation hospital or unit.

IV. POLICY:

To assure proper payment under the Medicare DRG payment system, the discharge/transfer status of patients must accurately reflect the level of post-discharge care to be received by the patient. The Tenet Facility leadership (i.e., Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer and Chief Financial Office) is responsible to assure the coordination of all system processes (including various Tenet Standards, department policies, procedures and practices) necessary to effectuate compliance with laws and regulations and timely and appropriate responses to inquiries from all external review sources, including the fiscal intermediaries.

V. PROCEDURE:

A. Tenet Facility Implementation

1. The attending physician is responsible for ordering:

   a. the release of a patient from the facility; and

   b. any subsequent care.

Under InterQual, the patient must fail to meet the continued stay criteria and must pass the discharge criteria.

2. The individual responsible for discharge planning (i.e., case manager, discharge planner, social worker) is responsible for completing a “Post Discharge - Services

Ordered" form, which shall reflect the discharge/transfer status of the patient. (See Attachment A for a sample form.)

3. If a patient's medical record does not contain appropriate documentation to accurately determine the discharge/transfer status, a claim for the stay shall not be submitted to Medicare for payment until this issue is resolved.

4. The Tenet Facility must have a UM Plan that assures compliance with all federal and state laws and regulations and with Tenet policies. The UM Plan must be approved by the Tenet Facility's Medical Executive Committee and Governing Board and must be reviewed and revised as necessary, but not less frequently than annually.

5. The Tenet Facility's UM Plan must define criteria for discharge/transfer screens designed to evaluate a patient's clinical stability and readiness for discharge/transfer.

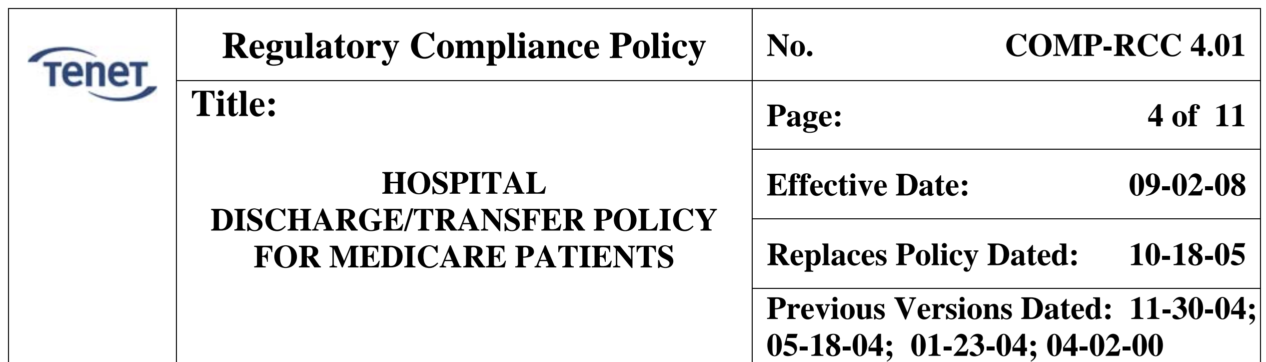
6. The Tenet Facility must utilize the UM Plan discharge/transfer screens to monitor the disposition of all inpatients.

7. The Tenet Facility must maintain and periodically, but no less frequently than annually, update a list of institutions and agencies at which patients receive care subsequent to their release from the Tenet Facility (e.g., a long-term care facility, cancer or children's hospital, or a psychiatric or rehabilitation hospital or unit) and relevant information about these facilities, such as their Medicare certification status (e.g., whether a hospital is PPS-exempt or non-acute; whether a SNF is Medicare-certified).

8. When home health services are ordered, the patient must receive the Tenet Facility's home health services patient choice form.

9. When the Tenet Facility becomes aware that a patient's care will not, or no longer, be covered by Medicare (e.g., where the patient may be moved to a portion of the facility that is not Medicare-certified), notice of the non-coverage should be issued immediately to the beneficiary, physician, and the facility's business office in accordance with the procedures established by the Case Management/Utilization Management Departments. (See Policy RCC 4.25 Hospital-Issued Notices of Noncoverage for Medicare Inpatients.)

10. The Tenet Facility must refer discharge/transfer orders for patients not meeting the minimum discharge/transfer criteria for physician/administrative review as defined by the Tenet Facility's UM Plan.



11. The Tenet Facility must assure that the coding of all discharges/transfers is consistent with all applicable federal and state laws and regulations. (See Attachment B – Medicare Guidelines for Discharge and Transfer and the CMS website for the annual Acute Inpatient PPS Final Rule for the transfer DRGs in effect for a given federal fiscal year.)

B. Consequences of Non-Compliance

The premature release or transfer of a patient or the extending of a hospital stay beyond the time when a discharge or transfer would be medically appropriate can expose the hospital to potential sanctions that may include but not be limited to, fines, penalties, EMTALA violations, loss of Medicare certification, and legal liability. CMS considers the discharge /transfer issue a vulnerability of the Medicare program and has devoted significant resources to safeguard against inappropriate payments resulting from incorrect coding of hospital discharges.

C. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate disciplinary action pursuant to all applicable policies and procedures, up to and including termination. Such disciplinary action may also include modification of compensation, including any merit or discretionary compensation awards.

VI. REFERENCES:

- Transmittal 149, Pub. 100-04, April 23, 2004

- CMS Acute Inpatient PPS Files for download (Table 5 of each year's final rule contains the transfer DRGs in effect for each federal fiscal year)

- CMS Report on Effects of Implementing Post Acute Transfer Policy

VII. ATTACHMENTS:

- Attachment A: Post Discharge – Services Ordered Sample Form

- Attachment B: Medicare Guidelines for Discharge and Transfer

POST DISCHARGE - SERVICES ORDERED
[SAMPLE FORM]

Check appropriate box and enter name of facility.

Short Term Non-PPS Hospital Services (05):

- ☐ **Children's Hospital:**____________________
- ☐ **Cancer Hospital:**____________________

Other Designated Services:

- ☐ **Federal Hospital (43):**____________________
- ☐ **Rehabilitation Hospital/Unit (62):**____________________
- ☐ **Long Term Care Facility (63):**____________________
- ☐ **Psychiatric Facility/Unit (65):**____________________
- ☐ **Medicare Certified SNF/Unit (03):**____________________
- ☐ **Home Health Services (06):**____________________

  Date Services to Begin:____________________

  Reason for Services:____________________

  - ☐ **Related to Reason for Admission**
  - ☐ **Unrelated to Reason for Admission**

Other Patient Status:

- ☐ **Non-Medicare Certified SNF/Unit (04):**____________________
- ☐ **Non-Medicare Certified SNF/Unit; Medicaid Certified (64):**____________________
- ☐ **Intermediate Care Facility (04):**____________________
- ☐ **Medicare Approved Swing Bed, this hospital & other institutions (61):**____________________
- ☐ **Short Term Care PPS Facility (02):**____________________
- ☐ **Hospice Facility (51):**____________________
- ☐ **Home with Hospice (50):**____________________
- ☐ **Home (01):**____________________
- ☐ **AMA (07):**____________________
- ☐ **Expired (20):**____________________
- ☐ **Other facility not classified above (70) (List name of facility and type of certification):**____________________

- ☐ **Discharge Planner/Case Manager:**____________________ **Date:**__________

Generic Form, UB-04 values (effective: 10-01-03, Revised: 05-18-04, 11-12-04, 11-19-07)

Medicare Guidelines for Discharge and Transfer

A. In General: When Medicare beneficiaries complete their stays at an inpatient hospital that is paid under the fee-for-service (FFS) Medicare inpatient prospective payment system (MIPPS), the discharge/transfer rules come into play. These rules also may come into play for Medicaid programs that use the DRG system as a basis for payment. Although these rules are often highly technical, it is extremely important to follow them carefully because noncompliance could result in significant administrative, civil, and/or criminal liability.

B. Medicare's Special Payment Rules for Discharges/Transfers:

1. Discharges are treated very differently from transfers for MIPPS purposes and, therefore, proper coding is essential.

2. As a general matter, a MIPPS hospital receives the full amount of a DRG payment from Medicare when a beneficiary is discharged from the facility. However, where the beneficiary is transferred to another MIPPS hospital, the transferring hospital is generally limited to a graduated per diem payment that may not exceed the full DRG payment. Both transferring and discharging hospitals are eligible for a cost outlier payment. Tr. A 98 26 (July 1, 1998)

3. As explained in more detail below, there are two exceptions to the general rule for discharges. First, a discharge under one of the transfer DRGs is treated as a transfer for Medicare payment purposes under certain circumstances. Second, a discharge is treated as a transfer if the patient is readmitted the same day to another MIPPS hospital or to a hospital paid under a state system excluded from MIPPS in accordance with 42 C.F.R. Subpart C, unless the readmission is unrelated to the initial discharge.

C. Important definitions:

1. A "discharge" occurs when a Medicare beneficiary (a) leaves a MIPPS acute care hospital after receiving complete acute care treatment or (b) dies in the hospital. 42 C.F.R. §412.4(a); see also Tr. A 01 39 (March 22, 2001) (Exhibit B-2).

2. A "transfer" occurs when a Medicare beneficiary in a MIPPS hospital is (a) transferred to another acute care MIPPS hospital or unit for related care or (b) discharged but then readmitted the same day to another MIPPS hospital, unless the readmission is unrelated to the initial discharge. 42 C.F.R. §412.4(b).

3. A "qualified discharge" is a discharge that is treated as a transfer for Medicare payment purposes. This occurs when a beneficiary whose inpatient hospital stay is classified under one of the transfer DRGs , is discharged from the hospital and is:

a. Provided home health services within three days of the discharge and the services relate to the condition or diagnosis for which the individual received inpatient hospital services. If the care does not begin until after the third day, this will be treated as a discharge for payment purposes even if the care was ordered to begin within three days of discharge. CMS has said that it will monitor hospital discharge patterns to determine whether home health care is

routinely being delayed until the fourth day. (63 Fed. Reg. 40,953, 40, 979 40,980 (July 31, 1998));

b. Admitted to a Medicare-certified skilled nursing facility ("MC-SNF") for related care, even if the services provided by the SNF are not Medicare covered. 63 Fed. Reg. 40978. A discharge to a SNF will not be considered a "qualified discharge" if the SNF is not Medicare certified. 63 Fed. Reg. at 40,978. Furthermore, in order to be considered a "qualified discharge," the beneficiary must be admitted directly from the hospital to the MC-SNF. If this does not occur, the discharge will not be treated as a transfer, even if the care (1) begins within the 30-day eligibility window and (2) is related to the acute care stay. (63 Fed. Reg. at 40,978); or

c. Admitted to a hospital or hospital unit that is not reimbursed under MIPPS, e.g. a longterm care, cancer, or children's hospital or a psychiatric or rehabilitation hospital or unit. (See 42 C.F.R. §412.4(c)).

D. Reimbursement Rules for Discharges, Transfers, and Qualified Discharges:

1. Hospitals deemed to have "discharged" their Medicare beneficiary patients are entitled to the full amount of the DRG payment for the inpatient stay, and any applicable outlier payment.

2. Except as otherwise provided in Section D.3 below for DRGs 209 – 211, hospitals deemed to have "transferred" their Medicare beneficiary patients are paid a graduated per diem amount for each day of the patient stay, not to exceed the DRG payment amount cap. The hospital receives twice the per diem amount for the first day and the per diem amount for each remaining day, up to the full DRG payment. (The hospital could also qualify for an outlier payment). 42 C.F.R. §412.4(f)(1).

Example: Assume that a patient is transferred after 2 days where the full DRG amount is $5,000 and the geometric mean length of stay is 5 days. The transferring hospital is entitled to $3,000 $2,000 for the first day and $ 1,000 for the second day.

3. Although the transfer payment rules generally also apply to "readmissions" and "qualified discharges," there is a special payment rule for qualified discharges assigned DRGs 209, 210, and 211 whereby the hospital receives 50% of the DRG for the first day and 50% of the per diem amount under the standard transfer payment methodology for each day of care (including the first day). (42 C.F.R. §412.4(f)(2)).

Example: Assume that a patient is discharged from a MIPPS hospital to a MC-SNF after 4 days where the full DRG amount is $10,000 and the geometric mean length of stay is 5 days; the hospital is entitled to $10,000, $5,000 for the first day (50% of the full DRG) plus $2,000 more for the first day(double the per diem) and $ 1,000 each for days two through four. See 67 Fed. Reg. 50,051 2 (August 1, 2002); see also 63 Fed. Reg. 40,982.

E. Compliance Concerns:

1. A hospital will face adverse action where it provides false or fraudulent information concerning a discharge or transfer.

2. Classifying a transfer as a discharge could result in improperly increased payments and could expose the hospital to recoupment and possible False Claims Act liability. CMS has noted that "the OIG has prepared several reports that examined hospitals' compliance with proper coding of patients' discharge status as transferred under our guidelines, and has found substantial noncompliance leading to excessive payments." 68 Fed. Reg. 45,346, 45,410 (August 1, 2003). CMS then stated that "hospitals found to be intentionally engaging in such practices may be investigated for fraudulent or abusive billing practices" and that it intends "to work with the OIG to develop the most appropriate response to ensure all hospitals are compliant with our guidelines." Id.

This would include a situation where, for example, a patient requests transfer to a different MIPPS hospital before care has been completed and the transferring hospital nevertheless characterizes the patient's departure as a "discharge," such as by noting in the patient's record "discharged against medical advice." As stated above, if a discharged patient is readmitted the same day to another MIPPS hospital, the stay at the discharging hospital will be treated as a transfer, unless the readmission was unrelated to the initial discharge. The CMS claims processing system identifies same day readmissions and the discharging hospital's Medicare fiscal intermediary (FI) or administrative contractor (MAC) will notify the hospital of the need to submit an adjustment claim if the hospital submitted a claim based on the patient having been discharged and the readmission was related to the initial discharge. (68 Fed. Reg. at 45,405 (August 1, 2003)).

3. Improperly classifying a discharge as a transfer could result in the hospital being underpaid.

4. It is important for hospital personnel to keep in mind that post-departure actions can affect the amount of payment due to the hospital for the inpatient stay. For example, a hospital's payment could be affected by whether the patient begins to receive home health services within three days after leaving the hospital. CMS has indicated that it will compare inpatient bills with home health service bills to determine if the home health care was provided within three days after departure from a MIPPS hospital. PM A 98 26 (July 1, 1998). This Transmittal includes additional detailed billing instructions for discharges/transfers. CMS also indicated that it would implement the OIG's recommendation to have CMS "establish edits in the Common Working File to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims." OIG 2003 Red Book at 17.

In order to assure proper Medicare billing, hospitals must (a) maintain, or as necessary determine, sufficient information about the institutions and/or agencies to which patients are being discharged/transferred (such as Medicare certification status) to make proper billing determinations and (b) take into account post-departure information that comes to its attention when making such a determination, including whether a patient who discharged (regardless of

the reason) is admitted on the day of discharge to another MIPPS hospital or hospital paid under a state system excluded from MIPPS in accordance with 42 C.F.R. Subpart C.

Tenet facilities are required to meet these expectations, but are not required to track patients after release from the facility. However, if a facility learns about any information that affects a payment, whether before or after departure of the patient, it must either code the original bill correctly or submit an adjustment bill. 63 Fed. Reg. at 40,980. The UB 92 has been revised to accommodate this. For example, a hospital may revise a bill if it learns that subsequent SNF or home health care, although ordered, was never provided. CMS has refused to require FIs to correct a Medicare bill automatically where their records do not indicate that such subsequent care was provided. 63 Fed. Reg. at 40,981.

If CMS finds "a continued hospital billing pattern for cases from the [transfer DRGs] as discharges and our records indicate that the patients are receiving post acute care services either from an excluded hospital, a SNF or within the 3 day home health service window, the hospitals may be subject to an intense prepayment bill review or possible action under the False Claims Act." Tr. A 98 26 at 3 of 34.

Tenet facilities need to be aware of the "Prohibited Acts" relating to discharges and transfers that are set forth in the Medicare Peer Review Organization ("PRO") Manual and listed in Section G of this Attachment B. One of these acts involves the premature discharge of a patient that causes the subsequent readmission of the patient to the discharging hospital. The OIG has stated that this situation raises quality of care and overpayment concerns. OIG 2003 Red Book at 15. A readmission of the same patient to the same hospital for a condition related to the initial discharge should be brought to the attention of facility leadership and a claim for the initial admission and/or readmission should not be submitted until after leadership review.

5. Swing Beds – Transfers to swing beds within the same facility should be treated as discharges for Medicare payment purposes, even for the "qualified discharge" transfer DRGs. See 63 Fed. Reg. at 40,976.

6. CMS and the OIG have undertaken a Joint Initiative to identify claims that were improperly paid as discharges. CMS takes the position that the normal four year reopening limit does not necessarily apply to post payment review of these claims because CMS allegedly has "good cause" for reopening these claims beyond that time. PM-01-113 (September 19, 2001). According to this PM, overpayment recoupment of these claims does not release the hospitals from potential FCA liability.

7. State Efforts Concerning Medicaid: Special rules for billing discharges and transfers may also apply to Medicaid programs that make payment on the basis of DRGs. See, e.g., OIG Report Partnership Review of Hospital Patient Transfers Potentially Paid as Discharges and Claimed Improperly Billed Under the Illinois Medicaid Program (No. A-05 -00-00049, June 18, 2001).

F. Quality Improvement Organization (QIO) Review of Discharges: 42 C.F.R. § 476.71(a)(6) requires QIOs, which were previously known as Peer Review Organizations (PROs) to determine the "medical necessity, reasonableness, and appropriateness" of hospital discharges. The following guidelines are from §4135 Medicare PRO Manual:

"PROs must conduct discharge review as specified in 42 CFR 476.71(a)(6). Use criteria to identify, for physician review, cases of potential premature discharge (i.e., the patient was not medically stable and/or discharge was not consistent with the patient's need for continued acute inpatient hospital care). (See §4510.) In length-of-stay review, identify cases of potential delayed discharge. For example, the patient was medically stable, and continued hospitalization was unnecessary, or nursing home placement or discharge to home with home care would have been appropriate in providing needed care without posing a threat to the safety or health of the patient. Factors that may result in an inconvenience to a patient or family do not, by themselves, justify a prolonged stay in the hospital. When such factors affect the patient's health, consider them in determining whether continued inpatient hospitalization was appropriate. Inpatient care rather than outpatient care is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that may cause the patient inconvenience in terms of time and money needed to care for the patient at home or for travel to a physician's office, or that may cause the patient to worry, do not justify a continued hospital stay or justify your approval of a higher-than-necessary level of care."

Although these guidelines purport to apply only to discharges, they could also come into play with respect to readmissions, transfers, and "qualified discharges."

G. Prohibited Actions - Section 4255.C. of the PRO Manual identifies certain actions that, when taken by the hospital, are presumed to have been intended to circumvent MIPPS: "Types of Prohibited Actions That Circumvent PPS.--Following are the four types of prohibited actions:

1. Premature Discharge of Patient That Results in Subsequent Readmission of Patient to Same Hospital.-- This prohibited action occurs when a patient is discharged even though he/she should have remained in the hospital for further testing or treatment or was not medically stable at the time of discharge. A patient is not medically stable when, in your [i.e. the PRO's] judgment, the patient's condition is such that it is medically unsound to discharge or transfer the patient. Evidence such as elevated temperature, postoperative wound draining or bleeding, or abnormal laboratory studies on the day of discharge indicate that a patient may have been prematurely discharged from the hospital. [See Section E.4. of this Attachment B for the proper response of the hospital when the same patient is readmitted to it for a condition related to the patient's initial discharge.]

2. Readmission of Patient to Hospital for Care That Could Have Been Provided During First Admission.--This prohibited action occurs when a patient is readmitted to a hospital for care that pursuant to professionally recognized standards of health care, could have been provided during the first admission. This action does not include circumstances in which it is not medically appropriate to provide the care during the first admission. [See Section B.3. of this Attachment B for the reimbursement effect of this readmission.]

3. Inappropriate Transfer of Patient From PPS Unit to PPS-Excluded Unit in Same Hospital.—This prohibited action occurs when a patient is admitted to an acute care part of the hospital even though the medical record shows that the patient required care in a PPS-excluded psychiatric or rehabilitation unit within the same hospital, a bed in the PPS-excluded unit was available at the time of initial admission, and the patient is subsequently transferred to the PPS-excluded unit. This also applies to similar transfers from PPS units to beds in hospital-based skilled nursing facilities (SNFs) and SNF swing beds. A transfer is considered an admission for purposes of payment under PPS. (See 42 CFR 412.4.)

4. Inappropriate Transfer of Patient From PPS-Excluded Unit to PPS Unit in Same Hospital.—This prohibited action occurs when a patient, who requires only the level of care being provided him/her in the PPS-excluded unit, is transferred to a PPS unit in the same hospital. A prohibited action also occurs when the transfer is from a PPS-excluded unit to a hospital-based SNF or swing bed."