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<th>PMI Case Management Policy</th>
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<th>PMI.CMT.102</th>
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<tbody>
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<td>Title:</td>
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<td>REQUIREMENT FOR PATIENT</td>
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<td>CHOICE FOR POST-HOSPITALIZATION SERVICES</td>
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<td>Effective Date:</td>
<td>05-12-16</td>
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<td>Previous Versions Dated:</td>
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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 greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:

The purpose of this policy is to ensure patients are provided a meaningful choice when selecting post-hospitalization Home Health (HH), Hospice, Long Term Acute Care (LTAC), Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) services.

III. DEFINITIONS:

A. “Case management” means a collaborative process of assessment, planning, facilitation, care coordination, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

B. “Inpatient” means any person who has been admitted to a Tenet Hospital for bed occupancy for purposes of receiving hospital services.

C. “Outpatient” means a person who has not been admitted to a Tenet Hospital as an Inpatient but is registered on the Tenet Hospital records as an Outpatient and receives services from the Tenet Hospital. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

D. Observation Services” or “Observation” means assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.

E. “Admitting or Attending Physician” means, in the context of this policy, a physician or any licensed independent practitioner who is legally accountable for establishing the patient’s diagnosis and has been granted admitting privileges by the Tenet Hospital’s Medical Staff. Emergency Department physicians may be considered Admitting or Attending Physicians when they have been granted admitting privileges by the Medical Staff.

F. “Physician Order” means an order from the Physician admitting the patient to the Tenet Hospital or the Physician responsible for the patient’s general medical management during the admission. The order may be electronic, in writing or be...
a telephone/verbal order as allowed by the Tenet Hospital’s Medical Staff Bylaws, Rules, Regulations or Policies.

IV. POLICY:

Patients who require HH, Hospice, LTAC, IRF or SNF services arranged as part of their inpatient or outpatient observation transition plan as ordered by the Physician will be notified of the availability of those services in the geographic area where the patient resides or the geographic area requested by the patient and/or patient representative. If the Tenet Hospital operates a Home Health Agency (HHA), Hospice, LTAC, IRF or SNF, the financial relationship will be disclosed to the patient at the time the patient selects the Tenet Hospital’s agency or service. HHA, Hospice or SNF representatives shall be entitled to patient information only pursuant to applicable patient authorization and in accordance with the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, and with the Tenet Hospital’s Facility Access Policy.

V. PROCEDURE:

A. Appropriate Patient Choice Form

1. The Patient Choice Form is provided in Attachment A. If the Tenet Hospital owns a HHA, Hospice, LTAC, IRF or SNF, the form should include the language included in the brackets on the attachment. The form may be amended by the Tenet Hospital to include the hospital logo and name. Tenet Hospitals must implement this form as written without any additional changes to the content, unless granted approval by the PMI Case Management Department prior to making the change.

B. Home Health, Hospice and Skilled Nursing Services List

1. The Case Management Department must maintain a list of local community HH, Hospice, LTAC, IRF and SNF providers. The list of these providers should include entities that request to be part of the hospital’s post-acute provider list. If a Tenet Hospital is contracted with Curaspan or Allscripts, these listings fulfill the requirement, as long as they include all of the providers requesting to be on the list.

2. If a post-acute provider is not included on the Curaspan, Allscripts or hospital list provided to the patient, the following items must be verified prior to adding a post-acute provider to the list:

   a. The post-acute provider is currently licensed. Request a copy of the license for the case management department files.
b. The post-acute provider is appropriately certified. Medicare certification can be verified at the CMS website [www.medicare.gov/HomeHealthCompare](http://www.medicare.gov/HomeHealthCompare) for HH and Hospice providers or [www.medicare.gov/nhcompare](http://www.medicare.gov/nhcompare) for SNF providers. The providers are not listed on the Compare sites until they are Medicare certified. There may be a lag between when the provider is certified and when they appear on the web site. Medicaid certification can be verified with the state agency.

3. If the post-acute provider does not provide the necessary services, it must not be placed on the hospital post-acute provider resource list.

4. A verified post-acute provider will remain on the hospital provider list unless one of the following events occur:

   a. The post-acute provider discloses to the hospital that such provider is no longer certified or its license has been suspended or revoked;

   b. The hospital becomes aware that the post-acute provider is no longer certified or its license has been suspended or revoked;

   c. The post-acute provider does not comply with the hospital’s policies and procedures including, but not limited to, the hospital’s Facility Access Policy; or

   d. The hospital determines that it is in the best interest of the hospital’s patients for quality of care reasons to remove the provider from the hospital post-acute provider list.

5. The hospital must contact its Regional Counsel prior to removing a post-acute provider from its resource list due to quality of care reasons.

C. Patient Choice Process

1. Hospital Case Management will complete an assessment of the patient’s post-acute needs to evaluate whether the HH, Hospice, LTAC, IRF or SNF services are appropriate for the patient’s needs and discuss the plan of care with the physician and the patient and/or patient representative. Hospital Case Management will explain the nature of the post-acute services planned or ordered by the patient’s physician and present the Patient Choice Form, with a list of the providers, to the patient and/or the patient’s representative.

2. Hospital Case Management will determine if the patient has previously received HH, Hospice, LTAC, IRF or SNF services.
a. If the patient has previously received HH, Hospice, LTAC, IRF or SNF services from a post-acute provider, Hospital Case Management will inquire as to whether the patient wishes to continue receiving services from the provider as well as whether the provider is able to continue to meet the patient’s care needs.

   (1) Patients requiring planned hospital readmissions and repeated post-acute services between hospital admissions may elect to make that their post-acute provider choice to be in effect for a year at a time.

b. In the event that a patient elects to change his or her choice of HH, Hospice, LTAC, IRF or SNF provider, the patient and/or patient representative is responsible for notifying the provider that the patient will not be continuing services.

3. The patient and/or patient representative is informed by Hospital Case Management if the physician has a recommendation for a specific provider. If the patient’s and/or patient representative’s preference or choice conflicts with the Physician’s recommendation, the patient’s and/or patient representative’s preference or choice will supersede the Physician’s recommendation. Hospital Case Management will notify the Physician of the patient’s and/or patient representative’s choice if it conflicts with the Physician’s recommendation. Any discussion with the patient and/or patient representative regarding the resolution of the conflict is the responsibility of the Physician if he/she disagrees with the patient’s and/or patient representative’s preference or choice.

4. Physicians must not refer patients to a provider in which they have a financial arrangement or ownership interest if that referral interest violates state and/or federal law. If Hospital Case Management is aware of such a financial arrangement or ownership interest, the Director of Case Management, Physician Advisor, and/or a member of the hospital Administrative team will inform the Physician of this policy.

5. Many third-party payers have a network of preferred providers. Hospital Case Management will assist the patient and/or patient representative regarding the preferred providers by providing any relevant information including which providers are on the payer’s preferred provider list and the estimated general cost of using non-network providers if the patient and/or patient representative elects to consider using a non-network provider.
6. Referrals will not be made to any entity that is known by Hospital Case Management not to be appropriately licensed and/or certified to provide the care the patient needs.

7. If the patient and/or patient representative selects an entity that does not provide the needed services, Hospital Case Management will discuss with the patient the options regarding care.

8. In cases where no preference is expressed, Hospital Case Management will assist the patient and/or patient representative to arrange the required services to meet the patient care needs within available resources and benefits.

9. After the choice has been made, Hospital Case Management will notify the appropriate provider(s).
   a. Hospital Case Management will provide the selected entity(ies) with the necessary information to assist in facilitating a safe and timely transition from the hospital to the care of the post-acute provider.
   b. Hospital Case Management will attempt to elicit and answer all questions from the patient and/or patient representative with respect to possible needed services, prior to the patient and/or patient representative signing the Patient Choice Form.

10. Once the Patient Choice Form is completed, it will become part of the patient’s hospital medical record.

D. Responsible Person

The Tenet Hospital’s Director of Case Management is responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Hospital, and that instances of noncompliance with this policy are reported to his/her Supervisor and the Tenet Vice President of Performance Effectiveness, PMI.

E. Auditing and Monitoring

Audit Services will audit adherence to this policy as part of the full scope audit process.
F. 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 performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- 42 CFR § 482.43
- 42 U.S.C. §1395 x (M)
- 42 U.S.C. §1395 x (ee)(2)(D)

VII. ATTACHMENTS:

- Attachment A: Patient Choice Form
Patient Choice Form

MRN: <Insert>
Date: <Insert>

Dear <Insert Patient Name>:

Your physician has recommended follow up care after you leave the hospital. You have the right to select any facility or agency to provide the care ordered by your physician. If you have insurance, they may designate a selected network of providers for you depending on the care needed. Regardless, it is your choice to select the facility or agency you prefer.

Type of services ordered by your physician: <select one>.

___ Skilled Nursing Facility
___ Home Health Agency
___ Hospice Services
___ Long Term Acute Care
___ Inpatient Rehabilitation Facility

Our Case Management Department will provide you with the necessary information and a list of facilities and agencies to assist you in making your decision. If you have insurance we will assist you by contacting them in order to obtain any necessary authorization for services. The list is provided to you in accordance with federal law and those facilities or agencies that are owned, operated or affiliated with <Insert Hospital Name> or its affiliates are <Insert NONE or list applicable facility or agency names>.

Federal and/or State regulations require a disclosure that your referring Physician may have a financial relationship or compensation arrangement with the facility or agency providing care after you leave the hospital. If you would like additional information regarding the possible existence and nature of any such relationship or arrangement, please contact your referring Physician.

Please indicate the name of the facility or agency you have selected on this form. If you do not have a preference, please indicate whether or not you will allow placement with the first available provider. Once you make your selection, the Case Management Department representative will make the necessary arrangements for you.

I have been provided information by the hospital to make this decision. I have been included in planning for the care I will need after leaving the hospital and agree with the care that is being arranged.

05-12-16
I have selected the following facility(ies) or agency(ies):


I will allow placement with the first available provider ____ Yes ____ No

I would like this choice to by valid for one year from the date of signature below. ___Yes ___No

Patient or Patient Representative: ____________________________ Date: ____________

Hospital Representative: ________________________________ Date: ____________