

## 1. Transfers to Another Acute Care Hospital (§ 412.4(b))

Medicare adopted its IPPS transfer policy because, if we were to pay the full DRG payment regardless of whether a patient is transferred or discharged, there would be a strong incentive for hospitals to transfer patients to another IPPS hospital early in their stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Currently, when a patient chooses to depart from a hospital against the medical opinion of treating physicians, the case is treated as a left against medical advice (LAMA) discharge and coded as discharge status "07—Left Against Medical Advice (LAMA)" on the inpatient billing claim form. Because, by definition, LAMA discharges are assumed not to involve the active participation of the hospital administration, our policy has been to treat LAMA cases as discharges. This policy applies even if the patient is admitted to another hospital on the date of the LAMA discharge. Consequently, we currently make a full DRG payment for any discharge coded as a LAMA case.

However, we are concerned that some hospitals may be incorrectly coding transfers as LAMA cases. The Office of Inspector General (OIG) issued a report in March 2002 (A-06-99-00045), asserting that of the approximately 60,000 LAMA discharges annually, 1,500 patients were subsequently admitted to another IPPS hospital the same day. The OIG performed a detailed review of the medical records at selected hospitals and found evidence that the hospitals actively participated in transferring the patients to a different IPPS hospital, yet the hospital coded the claim as a LAMA. OIG cited several examples of these cases:

"In the first example, the transferring hospital did not have an inpatient room available for the patient, who had been in the emergency room for 24 hours. The medical record showed that the treating physician contacted another PPS hospital to determine whether the hospital could accept the patient. Specifically, the medical record stated: 'Upon request of the patient, [hospital name] was contacted since there is a good possibility of transferring patient to [name of hospital]. At present, he has been in emergency room for 24 hours waiting for a bed.'"

In this example, despite the overt participation of the physician in securing the admission to the other IPPS

hospital and the fact that the transferring hospital did not have an inpatient room available for the patient, the claim was submitted as a LAMA discharge, rather than as a transfer to another IPPS hospital.

"In the second example, the patient was brought to the first hospital by ambulance. Subsequently, the patient's family indicated that they wanted a neurologist at another hospital to render the treatment needed by the patient. The attending physician contacted the neurologist in order to determine if the neurologist would accept, admit, and treat the patient. The medical record contained ample evidence of knowledge and participation of the transferring hospital, and the discharge should have been reported as a PPS transfer. Specifically, the medical record stated: 'Patient's family wanted to sign the patient out against medical advice and take her to [name of hospital]. The physician spoke with the neurologist at [name of hospital], who agreed to accept the patient. The patient's family signed the patient discharged against medical advice. All the risks of self-discharge were explained.'"

In this case, although the medical record indicated the patient wanted to leave against medical advice, there is also evidence that the patient's attending physician at the hospital participated in the transfer to another IPPS hospital. While we do not wish to discourage such participation and cooperation in cases where a transfer occurs, this situation would seem almost indistinguishable from other transfer situations. For instance, we have long recognized situations where patients are transferred from a rural hospital to an urban hospital for a surgical procedure, then back to the rural hospital to complete the recuperative care, as appropriate transfer situations as long as the transfers are medically appropriate. In such a case, the rural hospital would receive a payment under the transfer policy for the first portion of the stay, the urban hospital would also receive payment under the transfer policy for the care it provided, and the rural hospital would receive a full DRG payment as the discharging hospital for the recuperative care it provided upon the patient's return from the urban hospital. In such situations, each portion of the stay may be assigned a different DRG.

Therefore, we are proposing to expand our definition of a transfer under § 412.4(b) to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS

hospital, unless the first (transferring) hospital can demonstrate that the patient's treatment was completed at the time of discharge from that hospital. In other words, unless the same-day readmission is to treat a condition that is unrelated to the condition treated during the original admission (for example, the beneficiary is in a car accident later that day), any situation where the beneficiary is admitted to another IPPS hospital on the same date that he or she is discharged from an IPPS hospital would be considered a transfer, even if the patient left against medical advice from the first hospital.

Although we considered proposing a policy that would be based on whether the hospital actively participated in the transfer, and exempting from the transfer definition cases where the hospital had absolutely no knowledge that the patient intended to go to another hospital, we are not proposing such a policy for two reasons. First, it would be difficult to administer equitably a policy that required a determination as to whether the hospital or the physician had knowledge of the patient's intentions. Such a policy would require fiscal intermediaries to make a difficult judgment call in many cases. Second, if we were to base the determination of whether a case is a transfer on the level of involvement of the hospital and the physician caring for the patient, we would be creating a financial disincentive to hospitals for ensuring an efficient and cooperative transfer once a decision has been made by the patient or the patient's family to leave the hospital.

We recognize that, in some cases, a hospital cannot know the patient will go to another hospital. However, we note the claims processing system can identify cases coded as discharges where the date of discharge matches the admission date at another hospital. In these cases, the fiscal intermediary will notify the hospital of the need to submit an adjustment claim. However, if the hospital can present documentation showing that the patient's care associated with the admission to the hospital was completed before discharge, consistent with our current policy, the transfer policy will not be applied.

## 2. Technical Correction

Section 412.4(b)(2) defines a discharge from one inpatient area of the hospital to another area of the hospital as a transfer. Although this situation may be viewed as an intrahospital transfer, it does not implicate the transfer policy under the IPPS. Therefore, to avoid confusion and to be