

before being submitted to their fiscal intermediary and sent to CMS earlier this year.

Further, since the ultimate goal is improvement of the wage index, we believe this will be achieved with a more streamlined process in which fiscal intermediary work is not duplicated and is instead focused on the final data submitted by hospitals instead of preliminary data, of which nearly 40 percent ends up being revised under the current timetable. As noted above, these revisions under the current process often nullify the desk reviews performed by the fiscal intermediary.

We recognize the commenters' concern with respect to the interaction of this process with the collection of occupational mix data and the potential

adoption of OMB's new MSA definitions. As we proceed with developing the details of the occupational mix data collection for the FY 2005 wage index, we intend to schedule that collection effort in a way that accommodates this revised timetable. The details of that schedule will be forthcoming shortly.

Finally, as previously discussed, the ability of hospitals to assess whether they should request a withdrawal from a MGCRB reclassification will also be improved, thereby decreasing the likelihood that the final wage index will be dramatically different from the proposed wage index. For these reasons, we are adopting as final the proposed revisions to the wage data development

timeline and will use the revised timeline for the development of the FY 2005 wage index.

However, in order to address commenter concerns about the 30-day review period being too short, we are modifying the timetable to have the preliminary public use file on the CMS Web site in mid-September, thereby giving hospitals approximately 45 days instead of 30 days to review the preliminary wage data. Further instructions and a detailed timeline will be released in the form of a Program Memorandum.

The following table illustrates the timetable that will be applicable for the development of the FY 2005 wage index:

Timeframe	Steps in wage index development process
Mid-September	Preliminary and unaudited wage data file published as a public use file (PUF) on CMS Web site.
Mid-November	Deadline for hospitals to send requests for revisions to their fiscal intermediaries.
Early February	Fiscal intermediaries review revisions and desk review wage data; notify hospitals of changes and resolution of revision requests; and submit preliminary revised data to CMS.
Early March	Deadline for hospitals to request wage data reconsideration of desk review adjustments and provide adequate documentation to support the request.
Early April	Deadline for the fiscal intermediaries to submit additional revisions resulting from the hospitals' reconsideration requests. This is also the deadline for hospitals to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's policy interpretations.
Early May*	Release of final wage data PUF on CMS Web site.
Early June*	Deadline for hospitals to submit correction requests, to both CMS and their fiscal intermediary, for errors due to the mishandling of the final wage data by CMS or the fiscal intermediary.
August 1*	Publication of the final rule.
October 1*	Effective date of updated wage index.

*Indicates no change from prior years.

IV. Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

A. Transfer Payment Policy (§ 412.4)

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is

double the per diem amount for the first day (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day.

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: