

"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, in the May 19, 2003 proposed rule, we proposed 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 did not propose 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.

*Comment:* Commenters opposed the proposed expansion of the transfer policy to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital. They argued that situations in which a limited number of hospitals are abusing the payment rules should be handled by review of those hospitals' claims, and not through a policy change that will place additional burdens on all hospitals.

*Response:* We disagree that this policy expansion would create an additional burden on all hospitals. We note that it is our current policy to consider patients discharged from one IPPS hospital and admitted to another IPPS hospital on the same day as a transfer in all situations except LAMA situations, unless the original discharging hospital can document that the discharge was appropriate and unrelated to the subsequent same-day admission. We understand from the OIG that these situations are extremely rare, and in the vast majority of cases, same-day readmissions to another hospital are, in fact, transfers.

Our proposal would merely extend this current policy to LAMA situations. As is the case under our present policy, we believe it will be exceedingly rare that a patient leaves one hospital in LAMA status, and is readmitted to a second hospital on the same day for an unrelated purpose. Because the need for a hospital to supply documentation would only arise in these rare situations, we do not believe this policy change creates an additional burden for hospitals.

In relation to the appropriateness of a general policy expansion as opposed to a review and adjustment of individual hospital's claims, we believe a general policy expansion is necessary in this circumstance. As described in the proposed rule and above in this final rule, we considered proposing a policy that would be based on whether the hospital actively participated in the transfer and that would exempt from the transfer definition cases in which the hospital had absolutely no knowledge that the patient intended to go to another hospital. However, we did not propose such a policy because it would require a determination as to whether the hospital or the physician had