

knowledge of the patient's intentions. We believed that if we adopted such a policy, 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.

*Comment:* Several commenters wrote that CMS was overreacting to anecdotal examples and that the proposed policy was "not sustainable under any application of reasonableness." They suggested that, rather than put the burden on all hospitals due to the abuse from these isolated incidents, hospitals should be evaluated from the frequency of LAMA discharges. Those that fall outside of the "norm" could be investigated, similar to the outlier studies.

*Response:* We agree that the problems uncovered in the OIG's report on transfers reported as LAMAs are relatively small within the overall scope of the IPPS. In fact, we made the point to OIG in our comments on a draft of its report that their findings equated with one inappropriate LAMA discharge per hospital per year. However, the OIG found this problem was not spread equally across all hospitals, but occurred disproportionately in a small number of hospitals.

We believe we are establishing clear and unequivocal policies for handling those situations that do occur and that this policy change will have a minimal impact on the majority of hospitals nationwide. Consequently, we are finalizing the change to our regulations 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, effective for discharges occurring on or after October 1, 2003.

*Comment:* Commenters stated that the proposed expanded definition of a transfer provides no guidance to hospitals as to what would be acceptable documentation that the patient's treatment was completed at the time of discharge. Some commenters asked whether an exact match of the principal diagnoses codes for the two admissions would be used to determine that the same-day readmission was related to the prior discharge. One commenter suggested that it would be more appropriate for the fiscal intermediary to request medical documentation from both hospitals involved in the transfer in order to

determine whether a transfer payment should be made to the transferring hospital, rather than solely requesting documentation from the transferring hospital.

Another commenter asserted that CMS is placing the burden of correcting this situation on all hospitals rather than directing fiscal intermediaries to develop screens to identify these cases. In addition, they noted possible conflicts of sharing information between hospitals regarding patient care due to new HIPAA requirements.

*Response:* We anticipate the documentation necessary to establish that the readmission was unrelated to the prior, same-day discharge would be similar to the type of documentation relied upon by fiscal intermediaries and Quality Improvement Organizations (QIOs) to evaluate whether patients were discharged prematurely. (For example, section 4135 of the Peer Review Manual discusses discharge review.) That is, there are existing practices for determining that patients were medically unstable at discharge or the discharge was inconsistent with the patient's need for continued acute inpatient hospitalization. Therefore, there should be no breach in HIPAA disclosure requirements.

We are developing claims processing systems edits to more accurately identify transfers that are inappropriately coded as discharges. These edits identify claims that are entered with inappropriate discharge codes and will prevent payment to the second hospital if there is already a discharge from another hospital in the system for the same beneficiary on the same day. If this situation occurs, the claim from the first hospital is sent back to the hospital for correction, and the second claim is paid. We expect a similar edit that identifies same-day readmissions following a LAMA discharge would be added to the claims processing system edits.

*Comment:* One commenter requested clarification as to the appropriate discharge destination code in those situations when a patient left the first hospital against medical advice and the fiscal intermediary notifies this hospital of a subsequent same-day admission to another hospital.

*Response:* This situation is similar to those situations in which a hospital believes and intends to discharge a patient to home, but is subsequently notified that the discharge qualifies under the postacute care transfer policy because the patient received qualifying postacute care. The hospital would submit an amended bill coded to reflect the fact that the hospital now has

information that the patient received subsequent care.

## 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. In the May 19, 2003 proposed rule, to avoid confusion and to be consistent with the changes to § 412.4(b) described at section IV.A.3. of this preamble, we proposed to delete existing § 412.4(b)(2) from the definition of a transfer. We did not receive any comments on this proposal. Therefore, we are deleting existing § 412.4(b)(2) from the definition of a transfer.

## 3. Expanding the Postacute Care Transfer Policy to Additional DRGs (§§ 412.4(c) and (d))

Under section 1886(d)(5)(J) of the Act, a "qualified discharge" from one of 10 DRGs selected by the Secretary, to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section requires the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term "subsection (d) hospital" as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A SNF (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

In the July 31, 1998 IPPS final rule (63 FR 40975 through 40976), we specified the appropriate time period during which we would consider a discharge to postacute home health services to constitute a transfer as within 3 days after the date of discharge. Also, in the July 31, 1998 final rule, we did not include in the definition of postacute care transfer cases patients transferred to a swing-bed for skilled nursing care (63 FR 40977).